88-1546

No. ———

Supreme Court, U.S.
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IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

PACIFIC MUTUAL LIFE INSURANCE COMPANY, *et al.*,
Petitioners,

v.

HARRIETTE TURNBOW,
Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF NEVADA

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QUESTIONS PRESENTED

1. Whether, under the Employee Retirement Income Security Act ("ERISA"), an employer has established or maintained an "employee welfare benefit plan" by obtaining, and paying premiums for, a group health care plan with funding and claims-administration provided by an insurance company (thereby satisfying the Department of Labor regulations defining the employer involvement necessary to "establish" an insured plan).

2. Whether a working owner, partner or sole proprietor who, along with one or more common law employees, is covered by an ERISA-regulated plan and is eligible to receive benefits, is considered a "participant" or "beneficiary" for purposes of ERISA's civil enforcement provisions so that such individual's suit to recover benefits and redress breaches of fiduciary duties is governed by ERISA rather than by state law doctrines, including punitive damages.

PARTIES TO THE PROCEEDING

PACIFIC MUTUAL LIFE INSURANCE COMPANY*

BENEFICIAL ADMINISTRATION COMPANY**

PENSION ADMINISTRATION, INC.

JOHN F. McGOWAN

DONALD R. LAWRENZ, individually, and as Trustee of Beneficial Employees Security Trust

BENEFICIAL EMPLOYEES SECURITY TRUST

HARRIETTE TURNBOW

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* The following are non-wholly owned subsidiaries of Pacific Mutual Life Insurance Company as well as companies that may be deemed affiliates thereof:

United Planners Group, Inc.
United Planners Financial Services of America
Employee Benefits America Administration Corp.

** The following are non-wholly owned subsidiaries of Beneficial Administration Company as well as companies that may be deemed affiliates thereof:

Beneficial Employees Security Trust
Pension Administrators, Inc.
BEST Employers Association, Inc.
BEST Pro-Tek, Inc.
BEST Benefit Payments, Inc.
BEST Employee Benefit Administrators, Inc.
BEST Life Insurance Company of California

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HARRIETTE TURNBOW,
Respondent.

PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF NEVADA

The Petitioners, Pacific Mutual Life Insurance Company, Beneficial Administration Company, Pension Administration, Inc., Donald R. Lawrenz, individually and as Trustee for Beneficial Employees Security Trust, and Beneficial Employees Security Trust, respectfully pray that a writ of certiorari issue to review the judgment and opinion of the Supreme Court of Nevada entered in this proceeding on December 21, 1988.

OPINIONS BELOW

The Petition seeks review of a judgment and opinion of the Supreme Court of Nevada reported at 104 Nev. Adv.Op. 109 (1988), and which appears in the Appendix ("App.") at 1a to 5a. The judgment and opinion, and later amendment *nunc pro tunc*, of the First Judicial District Court of Nevada are unreported and appear in the Appendix at 6a to 8a.

JURISDICTIONAL STATEMENT

The judgment and opinion of the Nevada Supreme Court was entered on December 21, 1988. The jurisdiction of this Court is invoked under 28 U.S.C. § 1257(a).

STATUTES AND REGULATIONS INVOLVED

This case involves sections 3(1), 3(7), 3(8), 502(a), 505 and 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. §§ 1002(1), 1002(7), 1002(8), 1132(a), 1135 and 1144 (a), and 29 C.F.R. §§ 2510.3-1(j) and 2560.503-1(g)(2) (1987) promulgated under ERISA section 505. These provisions are reproduced in the Appendix at 9a to 12a.

STATEMENT OF THE CASE

The Nevada Supreme Court has ruled restrictively on two major, unresolved ERISA coverage and preemption issues. Reflecting a sharp conflict among at least five Circuits, the court held that a garden variety insured employee welfare benefit plan—identical to the overwhelming majority of American health care plans—is not considered "established or maintained" by an employer, and therefore is not subject to ERISA's coverage and preemption provisions. The court so ruled even though the employer had obtained and paid premiums for a group insurance plan, thereby satisfying the statutory definition of "employee welfare benefit plan" and the Department of Labor regulations. Alternatively, the court held that even assuming the plan is ERISA-regulated, a working owner who, along with one or more common law employees, is covered by the plan and is eligible to receive benefits, is not a "participant" or "beneficiary" for purposes of ERISA's civil enforcement provisions. Creating a serious dysfunction between ERISA's civil enforcement scheme and all of its other regulatory provisions which cover such individual, the court ruled that a suit by that individual to recover plan benefits and redress breaches of fiduciary duties is not governed by ERISA but rather by conflicting state law doctrines, including punitive damages.

A. The Facts

In the early 1970's, Petitioners Pacific Mutual Life Insurance Company ("Pacific Mutual"), as insurer, and Beneficial Employees Security Trust ("B.E.S.T."), a multiple employer trust, entered into an agreement by which Pacific Mutual issued to B.E.S.T. a Master Policy providing group health insurance. B.E.S.T. then offered the group insurance coverage to employers with small businesses, nationwide, as a funding vehicle for their individual employee welfare benefit plans.

B.E.S.T. itself, as a multiple employer trust ("MET"), was not "established or maintained" by an employer, and thus was not an employee welfare benefit plan as defined in ERISA section 3(1), 29 U.S.C. § 1002(1). Individual private sector employers subscribing to B.E.S.T., however, used the Master Policy as a funding vehicle to establish separate, single-employer ERISA plans at favorable rates otherwise available only to larger employers. These employers also obtained a professionally-run administrative program. The plan administrator, Petitioner Beneficial Administration Company, handled billings, collections, commissions, and payment of premiums to Pacific Mutual; it was also responsible for compliance with ERISA's reporting and disclosure requirements. Pacific Mutual performed initial claims-handling, paid approved claims, and served as ERISA claims review fiduciary.

In November, 1974, The Bottle Stop, a retail liquor store in Nevada, selected through its insurance agent the "American Series Plan," one of several benefit programs available under the Master Policy, in order to fund a health care plan. The "American Series Plan" summary plan description defined the term "eligible employees" as including: "all active full-time permanent employees regularly working the firm's normal work week (30 hours or more per week). Partners or Owners are considered 'employees' for the purpose of this Plan

if they meet eligibility rules." The Bottle Stop's application listed four individuals as full-time "employees," including Respondent Harriette Turnbow ("Turnbow"). A sole proprietor, Turnbow not only managed the store, but worked alongside three common law employees including her daughter. The Bottle Stop paid all insurance premiums each month from its company account. It also participated in the plan's administration by obtaining enrollment cards from all four individuals, having its insurance agent explain the coverage to the participants, and by paying an enrollment fee and monthly service charges.

Pacific Mutual issued "American Series Plan" certificate booklets to the four plan participants, including Turnbow. Advising that the "American Series Plan" was governed by ERISA, the booklets contained an ERISA summary plan description which covered all information required by ERISA including (1) the name of the plan, (2) the plan identification number, (3) the type of administration and type of welfare plan, (4) the plan administrator,[1] (5) the agent for service of process, (6) the plan trustee, (7) the source of plan contributions, (8) the claims procedures, including the ERISA review procedure for denied claims, and (8) a "Statement of ERISA Rights."

In August of 1981, Turnbow suffered a stroke and became totally disabled. After she applied for benefits under the "American Series Plan," Pacific Mutual paid her medical benefits for a number of years. The Bottle Stop maintained its group insurance coverage from November, 1974 until May of 1983, when it requested termination because of premium increases. Pursuant to an extension of benefits period, Turnbow received benefits

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[1] As designated plan administrator, Beneficial Administration Company filed an annual Return/Report of Employee Benefit Plan (Form 5500), in accordance with ERISA, for the years that The Bottle Stop maintained coverage under the "American Series Plan."

until April of 1984. Turnbow submitted no additional claims, nor did she request a conversion policy.

On April 27, 1987, Turnbow filed her First Amended Complaint in the First Judicial District Court of Nevada. It alleged, in essence, that at the time of disability, Turnbow had a "vested" right to a "contractually set maximum" $1,000,000 benefit under the "American Series Plan," and moreover that the coverage was cancelled only because a conspiracy among Petitioners had raised the premiums to such an excessive degree (from approximately $200 per month to over $1,250) that The Bottle Stop was forced to terminate coverage.

ERISA's civil enforcement provisions, ERISA section 502(a), 29 U.S.C. § 1132(a), supply an exclusive federal remedy for failure to pay benefits due under an employee welfare benefit plan. As fiduciaries or service providers, Pacific Mutual, B.E.S.T., Beneficial Administration Company and Lawrenz [2] admittedly were "parties in interest" as defined by ERISA.[3] Excessive charges and premiums under the "American Series Plan" would violate ERISA's fiduciary responsibility and prohibited transaction rules for which ERISA supplies both an exclusive federal remedy and exclusive federal court jurisdiction.[4]

Rather than pursuing any of the ERISA claims available to her, Turnbow made only state law claims for breach of contract to pay the "contractually set maximum" $1,000,000 benefit, breach of an implied covenant, violation of Nevada revised statutes, Chapter 686A, and Nevada Administrative Code, 686A, conspiracy, fraud and negligence, and sought plan benefits, emotional distress damages and punitive damages.

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[2] Petitioner Donald R. Lawrenz served as trustee of B.E.S.T.

[3] ERISA section 3(14)(B), 29 U.S.C. § 1002(14)(B).

[4] ERISA sections 404(a)(1), 406(a), 408(b)(2), 502(a), (e)(1), 29 U.S.C. §§ 1104(a)(1), 1106(a), 1108(b)(3) and 1132(a), (e)(1).

B. The Trial Court Granted Summary Judgment Based On ERISA Coverage And Preemption

On May 28, 1987, Petitioners filed a Motion to Dismiss, supported by affidavit, in the First Judicial District Court asserting ERISA coverage based on the Act's definition of "employee welfare benefit plan" as including "*any* [health care] plan, fund, or program . . . established or maintained by an employer . . . *through the purchase of insurance or otherwise* . . ." (emphasis added). ERISA section 3(1), 29 U.S.C. § 1002(1).[5] It also asserted ERISA preemption based on the Act's preemption and civil enforcement clauses in sections 514 (a) and 502(a), 29 U.S.C. § 1144(a) and 1132(a), and this Court's decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

By order granting summary judgment, the court upheld ERISA coverage and preemption. Applying the statutory definition and Department of Labor criteria, 29 C.F.R. § 2510.3-1(j) (1987), the court held that The Bottle Stop had established an ERISA-covered plan.[6] Furthermore, it held that ERISA preempted all of Turnbow's state law causes of action and entered summary

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[5] The ERISA jurisdictional section, section 4(a)(1), 29 U.S.C. § 1003(a)(1), states that the statute covers any employee benefit plan established or maintained by an employer "engaged in commerce or in any industry or activity affecting commerce." The liquor industry in which The Bottle Stop was engaged is, beyond question, an industry or activity affecting interstate commerce.

[6] For a group insurance plan to be ERISA-covered, the court held that at least one of four criteria for employer-involvement set forth in the regulations must be met. The court found that because the "American Series Plan" was applied for, and issued, under The Bottle Stop's name, the employer endorsed, and did not merely "advertise," the plan. It also found that the employer paid all the premiums through a company account. In addition, it found that the employer procured the "Plan" for all individuals listed as full-time employees, including Turnbow; thus, employee participation was automatic. App. at 6a-8a.

judgment without prejudice, apparently to protect her right to pursue ERISA remedies. App. at 7a.

C. Reversal By The Nevada Supreme Court

On appeal, the Nevada Supreme Court, acknowledging a Circuit conflict, reversed the summary judgment order. It held that to create a non-collectively bargained ERISA plan, an employer must demonstrate that it is "committed to the continuance" of the plan by maintaining it for a substantial span of years, presumably in excess of a decade. It held, therefore, that The Bottle Stop, which had cancelled its insurance coverage for reasons of business necessity after approximately eight and one-half years, had never established an ERISA plan. Alternatively, it held that even if The Bottle Shop had established such a plan, ERISA did not preempt Turnbow's claims, including those to plan benefits. It ruled that Turnbow was not a "participant" or "beneficiary," and therefore her claims were governed by state law rather than by ERISA's civil enforcement provisions. App. at 1a-5a. The court reached these conclusions, which conflict with those of three Circuits, notwithstanding that (a) ERISA section 3(1) broadly defines "employee welfare benefit plan" as including "any plan" established "through the purchase of insurance or otherwise", and Congress intended that even this "coverage . . . be construed liberally," Senate Rep. No. 93-127 (1973), *reprinted in* 1974 U.S. Code Cong. & Admin. News 4838, 4854; (b) the practical effect of the court's decision will be to resurrect state law as the principal mechanism for regulating employee welfare benefit plans, despite congressional intent that plan regulation be "exclusively a federal concern," *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987), and to reopen a door to punitive damages closed by this Court in *Pilot Life*, *supra*, thus raising substantial economic disincentives to insured plans; and (c) the exclusion from ERISA's civil enforcement scheme of the working self-employed, de-

spite their participation in ERISA plans and eligibility to receive benefits, will create a serious dysfunction in ERISA which includes these individuals in all of its other regulatory provisions, and cause the "mutually exclusive pockets of federal and state jurisdiction within a plan," and "conflicting and inconsistent State and local regulation," against which this Court warned in *Fort Halifax Packing Co. v. Coyne*, 107 S. Ct. 2211, 2217 (1987) and *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99, 107-08 (1983).

D. Finality Of Decision

The Nevada Supreme Court judgment and opinion on ERISA coverage and preemption is the law of the case and final for purposes of 28 U.S.C. § 1257.

REASONS FOR GRANTING THE WRIT

I. The Nevada Supreme Court's Decision Conflicts With Congress' Express Directive That ERISA Uniformly Encompass All Employee Welfare Benefit Plans, Self-Funded And Insured Alike, Preempting Parallel State Law Claims.

Review of the Nevada Supreme Court's decision is essential to restore Congress' express directive that ERISA uniformly encompass *all* employee welfare benefit plans, self-funded and insured alike, and preempt all state law claims relating to their administration. The state high court decision intentionally frustrates these congressional goals in all respects.

ERISA is a "comprehensive and reticulated statute," *Nachman Corp. v. Pension Benefit Guaranty Corp.*, 446 U.S. 359, 361-62 (1980), designed to make the regulation of employee benefit plans "exclusively a federal concern," *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987) (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)). ERISA, moreover, is built on the premise that employers should be encouraged to

provide financially *stable* employee benefit plans, *see*, ERISA section 2(a), 29 U.S.C. § 1001(a); and Congress recognized that cost-effective group insurance was essential to this goal, *see also, Employee Security Benefit Act of 1974: Material Explaining H.R. 12906*, 120 Cong.Rec. 3977, 3981-82 (1974); *Wadsworth v. Whaland*, 562 F.2d 70, 78 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978) (Congress recognized that insurance was the most common source of plan funding). Indeed, insured health care plans are not only the most stable type of plan, but often the *only* type realistically available for small and medium sized employers.[7]

In enacting ERISA, Congress also sought to replace the conflicting system of state and local regulation with "a *uniform* source of law for evaluating . . . fiduciary conduct," thereby ensuring "national uniformity" in the administration of both self-funded and insured plans (emphasis added). *See Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 n. 20 (1983); Introductory statement of Senator Javits on S. 1557, *reprinted in* 1 Legislative History of the Employee Retirement Income Security Act of 1974, 273, 279 (1976); *see also* 120 Cong. Rec, 29,928, 29,933 (1974) (remarks of Sen. Williams); 29,192, 29,197 (remarks of Rep. Dent). To establish federal preeminence, Congress enacted a detailed set of standards and duties to guide fiduciaries, and also vested the federal courts with *exclusive* jurisdiction over suits alleging a breach of these duties. ERISA sections 404(a)-412, 502(e)(1), 29 U.S.C. §§ 1104(a)-1112, 1132(e)(1).

To ensure that state law would not intrude in plan administration, Congress armed ERISA with a general preemption clause of "unparalleled breadth." ERISA sec-

[7] Battelle Human Affairs Research Centers, *Employee Welfare Benefit Plans and Plan Sponsors in the Private Nonfarm Sector in the United States*, 1978-79, Vol. IV, 25, 28, 37-38 (*"Battelle Study"*). A single adverse experience can bankrupt a self-funded plan for all but the largest of employers. *Id.* at 28, 37-38.

tion 514(a), 29 U.S.C. § 1144(a). *Holland v. Burlington Industries, Inc.*, 772 F.2d 1140, 1147 (4th Cir. 1985), *summarily aff'd*, 477 U.S. 901 (1986). Congress added "six carefully integrated civil enforcement provisions" which have their own "preemptive force" and provide an "exclusive" federal remedy in suits involving either self-funded or insured plans. ERISA section 502(a), 29 U.S.C. § 1132(a). *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54-6 (1987).[8] ERISA thus embodies what this Court recently described as a "'complete pre-emption' doctrine," *Caterpillar Inc. v. Williams*, 107 S. Ct. 2425, 2430 (1987).

The Nevada Supreme Court's decision is at the forefront of a growing number of decisions (*see* citations *infra* at 16-19) that intentionally seek to nullify ERISA's broad coverage and preemption over employee welfare benefit plans by the simple expedient of labeling them "non-ERISA covered." This parochial attempt to resurrect state law as the principal mechanism for regulating these plans contravenes directly this Court's holding in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). Furthermore, since over 90% of all plan sponsors are small and medium sized employers who cannot self-fund and are dependent upon group health insurance,[9] these decisions, in essence render ERISA and *Pilot Life* a "dead letter" for over 90% of all employers. Unless the state high court decision is reversed, two of Congress' most important goals in enacting ERISA—broad plan cover-

[8] ERISA's civil enforcement provisions preempt both common law claims, *Pilot Life*, *supra*, and claims based on state insurance codes. *See Kanne v. Connecticut General Life Ins. Co.*, 859 F.2d 96, 99 (9th Cir. 1988) (as amended in 1989) (*per curiam*); *Anschultz v. Connecticut General Life Ins. Co.*, 850 F.2d 1467, 1469 (11th Cir. 1988); *In Re Life Ins. Co. Of North America*, 857 F.2d 1190 (8th Cir. 1988); *Commercial Life Ins. Co. v. Superior Court*, 47 Cal. 3d 473 (1988).

[9] *Battelle Study* 25, 28, 37-38.

age and preemption, ensuring uniform federal regulation over all plans—will be seriously eroded.

A. *Congress Deliberately Adopted An Expansive Definition Of Employee Welfare Benefit Plan Which The State Court Intentionally Overturned.*

In enacting ERISA, Congress carefully crafted the Act's coverage and preemption provisions to encompass *all* employee welfare benefit plans, self-funded and insured alike. The Nevada Supreme Court's decision, by creating a coverage loophole coextensive with the statute itself, would destroy this important principle of uniformity and permit issues that go to the heart of ERISA's fiduciary standards and civil enforcement provisions to be litigated under state law principles, which include punitive damages.

ERISA section 3(1), the controlling statutory provision, contains an expansive definition of "employee welfare benefit plan" as including "*any* plan, fund, or program . . . established or maintained by an employer . . . providing . . . *through the purchase of insurance or otherwise*, (A) medical, surgical, or hospital care or benefits . . . ." (emphasis added). 29 U.S.C. § 1002(1). Congress, moreover, intended that even this broad "coverage . . . be construed liberally." Senate Rep. No. 93-127 (1973), *reprinted in* 1974 U.S. Code Cong. & Admin. News 4838, 4854; House Rep. No. 93-533 (1974), *reprinted in* 1974 U.S. Code Cong. & Admin. News 4639, 4656 (ERISA covers "all private employee benefit plans under Commerce Clause jurisdiction," with stated exceptions); *see also Blau v. Del Monte Corp.*, 748 F.2d 1348, 1352 (9th Cir. 1984) (as amended in 1985), *cert. denied*, 474 U.S. 865 (1985).

The Department of Labor, the agency responsible for the enforcement of ERISA, has promulgated regulations on section 3(1) providing, in the clearest of terms, that an employer's obtaining of group health care insurance,

and payment of premiums, without more, establishes an ERISA-covered plan.[10] The regulations, which encompass both the direct purchase of insurance and an employer's subscription to a MET, provide that a group insurance plan is ERISA-covered unless there is *no* employer involvement in the plan. 29 C.F.R. § 2510.3-1(j) (1987) lists four specific criteria, all of which must be met, if a plan is to be exempt from ERISA coverage:

> (1) No contributions are made by an employer . . .;
>
> (2) Participation . . . is completely voluntary for employees . . .;
>
> (3) The sole functions of the employer . . . are, without endorsing the program, to permit the insurer to publicize the program to employees . . . [and] to collect premiums and to remit them to the insurer; and
>
> (4) The employer . . . receives no consideration . . . other than reasonable compensation . . . for administrative services actually rendered.[11]

The Bottle Stop's plan was a garden variety employee welfare benefit plan fitting squarely within the statutory definition and the regulations. The overwhelming major-

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[10] Congress specifically empowered the Department of Labor to issue regulations under ERISA, and its construction of the statute, if not in conflict with its express terms, is therefore controlling. ERISA section 505, 29 U.S.C. § 1135. *See Buczynski v. General Motors Corp.*, 616 F.2d 1238, 1242-43 (3d Cir. 1980), *aff'd*, 451 U.S. 504 (1981); *see also Chemical Manufacturers Ass'n v. National Resources Defense Council, Inc.*, 470 U.S. 116, 126 (1985); *Batterton v. Francis*, 432 U.S. 416, 428-429 (1977); 2 K.C. Davis, *Administrative Law Treatise*, Section 7:8 at 36-37 (1979).

[11] If any one of these criteria is not met the plan is ERISA-covered. *See Kanne v. Connecticut General Life Ins. Co.*, 859 F.2d 96, 98-99 (9th Cir. 1988) (as amended in 1989) (*per curiam*); *Donovan v. Dillingham*, 688 F.2d 1367, 1372-73, 1375 (11th Cir. 1982) (*en banc*); *see also* DOL Opinion Letters 82-059A, 81-84A, 81-73A, 80-10A, and 79-54(A).

ity of employer-sponsored health care plans, which cover over 145 million working Americans and their dependents,[12] are established simply through the purchase of insurance, with employer involvement generally limited to selecting benefits, enrolling participants and paying premiums.[13] Furthermore, claims administration for the overwhelming majority of these insured plans is conducted not by the employer, but rather by an insurer serving as claims review fiduciary under ERISA section 503, 29 U.S.C. § 1133.[14] *See, e.g., LeFebre v. Westinghouse Electric Corp.*, 747 F.2d 197, 203 (4th Cir. 1984); *Schulist v. Blue Cross*, 553 F.Supp. 248, 252 (N.D. Ill. 1982), *aff'd.*, 712 F.2d 1127 (7th Cir. 1983). Far from requiring that plan administration be performed by the employer, ERISA expressly authorizes the allocation of *all* administrative duties without affecting coverage. *See* ERISA section 405(c)(1), 29 U.S.C. § 1105(c)(1); *see also* 29 C.F.R. § 2560.503-1(g)(2) (1987). Indeed, ERISA section 3(16)(A) defines the plan "administrator" as including "(i) the person specifically so designated by . . . the instrument under which the plan is operated [*or*] . . . (ii) if an administrator is not so designated, the plan sponsor. . . ." 29 U.S.C. § 1002(16)(A)(i), (ii).

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[12] *Statistical Abstract of The United States* (108 ed. 1988) 92.

[13] Scallet, *The Regulation of Multiple Employer Trusts: Past, Present & Future*, 61 Wash. U.L.Q. 359, 381 (1983) ("*Regulation of METS*"). *See 1988 Foster Higgins Health Care Benefits Survey* 23 ("*1988 Foster Higgins Survey*") (84% of employers insure their health care plans, or self-fund with stop-less insurance coverage; for employers with less than 1,000 employees, 95% insure such plans or self-fund with stop-loss coverage).

[14] *Regulation of METS* at 381; *Battelle Study* 43. 93% of *all* employers, self-funded and insured alike, use an insurer or third-party administrator for claims administration. *1988 Foster Higgins Survey* 24.

In summary, this is a textbook ERISA case in all respects. The Bottle Stop's plan was plainly covered by ERISA section 3(1), and Turnbow's claims are inseparably intertwined with ERISA's fiduciary standards and civil enforcement provisions in section 404(a), 503 and 502(a). Their eventual determination depends on an examination of the terms of the plan, ERISA's fiduciary responsibility and prohibited transaction rules, and the actual conduct of Petitioners as fiduciaries and parties in interest. In addition, the fiduciary responsibility and prohibited transaction rules are areas of *exclusive* federal court jurisdiction. ERISA section 502(e)(1).

B. *The State Court Decision, By Mandating A Long-Term Duration Requirement, Imposes An Illogical And Unworkable Coverage Standard Which Conflicts With ERISA's Uniform Coverage Provisions.*

Ignoring a common sense reading of the Act, the Nevada Supreme Court held that in order to establish an ERISA-covered plan, an employer must maintain it for a substantial "incubation" period (apparently at least a decade), and cannot terminate it earlier even for business necessity. This most restrictive ruling conflicts with congressional purpose to encompass *all* employee welfare benefit plans as shown by the deliberate breadth of section 3(1), the regulations, and section 89(k) of the Internal Revenue Code.[15] The decision, moreover, creates an illogical and unworkable standard for ERISA coverage which few plans—insured or self-funded—could meet. Only after a substantial span of years can it be determined, retrospectively, whether an employer was sufficiently "committed [to the plan's] continuance" for

[15] Section 89, part of the Tax Reform Act of 1986, mandates that effective plan years beginning in 1989, employee welfare benefit plans must be in writing in order to meet certain qualification standards; it simply requires—in terms of duration—that a plan be "established with the intention of being maintained for an indefinite period of time." 26 U.S.C. § 89(k)(1)(E).

it ever to have been considered ERISA-covered. This standard evidently would strip from ERISA protection *all* non-collectively bargained employee welfare benefit plans set up since 1980.[16]

By simply labeling an employee welfare benefit plan "non-ERISA governed," the Nevada Supreme Court deliberately attempts to upset ERISA's carefully crafted balance between federal and state law, and nullify its coverage and preemption provisions for the vast majority of American health care plans. A dispositive decision by this Court is urgently required to restore the critical balance struck by Congress in ERISA and reaffirm the preeminence of ERISA's civil enforcement remedies over *all* employee welfare benefit plans, self-funded and insured alike.

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[16] The court's decision also conflicts in principle with this Court's decision in *Fort Halifax Packing Co. v. Coyne*, 107 S. Ct. 2211 (1987). The majority opinion ruled that ERISA preemption extends to claims under any employee welfare benefit plan (defined as one affording "benefits whose provision by nature requires an ongoing administrative program."). In the Court's view, a one-time severance payment to all employees on closing a plant did not require an employer to face periodic demands on its assets that create a "need for financial coordination and control," and thus require an "ongoing administrative program" to meet the employer's obligations. 107 S. Ct. at 2217-18. The dissenting justices concluded that an "administrative scheme" was not even a pre-requisite for ERISA coverage and preemption. *Id.* at 2224-25. Most significantly, no duration requirement for maintaining a plan at all was set by either the majority or the dissent. In contrast, the employer's establishment of a group insurance plan, and its regular payment of premiums, require the "need for financial coordination and control" found significant in *Fort Halifax*, *supra*, 107 S. Ct. at 2218. Furthermore, insurance benefits, by nature, require an "ongoing administrative program," *id.*, for enrolling new participants, advising them on their rights, and, most importantly, for the processing and review of claims. ERISA sections 3(16)(A)(i), (ii), 405(c)(1), 503; 29 U.S.C. §§ 1002(16)(A), (i), (ii), 1105(c)(1), 1133; 29 C.F.R. § 2560.503-1(g)(2) (1987).

II. The Nevada Supreme Court's Decision, Which Conflicts With The Decisions Of Three Circuits, Reflects An Increasingly Significant Circuit Split, And Wide-Spread Division And Error In The Lower Courts, Which Can Only Be Resolved By This Court.

The Nevada Supreme Court's decision, which conflicts with the decisions of three Circuits, is not an isolated decision. Instead, it reflects an irreconcilable conflict among at least five of the Circuits, and increasing division and error in the lower courts, on ERISA's threshold issues of coverage and preemption.

The state high court drew the essence of its decision from the Fifth Circuit's opinion in *Taggart Corp. v. Life & Health Benefits Admin. Inc.*, 617 F.2d 1208 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030 (1981). This opinion—like the ones that follow it, including the Nevada decision—shares the fundamental misperception that ERISA coverage depends not on the statutory definition in section 3(1) but on how a plan is funded or administered. *See* Scallet, *The Regulation of Multiple Employer Trusts: Past, Present & Future*, 61 Wash. U.L.Q. 359, 387-88 (1983). ERISA, however, gives an employer *multiple* funding and administration options—including self-funding and performance of all administrative duties by others—without in any way affecting coverage.[17]

Taggart Corp. first held that a MET was not itself an ERISA plan. It then turned to an argument advanced in an *amicus* brief by the Secretary of Labor that ERISA governed the plaintiff's claims because the employer's subscription to the trust created a separate, single-employer ERISA plan. The court rejected this argument based on its assessment that an employer's active performance—as opposed to delegation—of administrative duties was a *sine qua non* for ERISA plan coverage.

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[17] *See* ERISA sections 3(1), 2(16)(A), (i), (ii), 405(c)(i), 503; 29 U.S.C. §§ 1002(1), 1002(16)(A)(i), (ii), 1105(c)(i), 1133; 29 C.F.R. § 2560.503-1(g)(2) (1987); *see also Battelle Study* 37-38.

It consequently ruled that the employer did not establish an ERISA plan because it did not "[participate] in . . . [its] day-to-day operation or administration," and simply paid premiums to a "purveyor of insurance." *Id.* at 1210-11.[18]

Establishing a clear conflict, the Eleventh Circuit in *Donovan v. Dillingham*, 688 F.2d 1367, 1375 (11th Cir. 1982) (*en banc*), expressly disagreed with *Taggart Corp.* Endorsing the Department of Labor regulations, the court held that an individual employer, by subscribing to a MET, can establish its own, single-employer ERISA plan. To determine ERISA coverage, the court applied a four-part test to see whether a decision to extend benefits had become a reality—one must be able to ascertain the "[1] intended benefits, [2] beneficiaries, [3] source of financing, and [4] procedures for securing benefits." It also ruled that the employer's purchase of a group insurance policy "offers *substantial* evidence that a plan . . . has been established." *Id.* at 1373.[19]

The Tenth Circuit noted a "split of authority" a year later in *Roe v. General American Life Ins. Co.*, 712 F.2d 450, 452 (10th Cir. 1983). Citing section 3(1) and *Donovan*, it held that the employer established an ERISA plan by obtaining a group disability insurance policy

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[18] The Seventh Circuit had reached a similar holding in *Wayne Chemical, Inc. v. Columbus Agency Service Corp.*, 567 F.2d 692, 699 (7th Cir. 1977), where the employer obtained group health insurance for its employees by subscribing through its broker to a MET. The court ruled that the employer did not establish an ERISA plan because it did nothing more than apply for insurance, and pay insurance premiums, and failed to participate in the trust's administration.

[19] More recently, in *Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277, 280 (11th Cir. 1987), the Eleventh Circuit held that an ERISA plan existed based on the presence of employer-sponsored group insurance policies. It ruled that "the insurance policies in this case constitute a 'plan' as defined by ERISA. . . ." 833 F.2d at 280.

jointly paid for by the employer and its employees.[20] Also joining the conflict, the Ninth Circuit rejected *Taggart Corp.* in two recent cases involving METs, *Credit Managers Ass'n v. Kennesaw Life and Acc. Ins. Co.*, 809 F.2d 617, 625 (9th Cir. 1987) and *Kanne v. Connecticut General Life Ins. Co.*, 859 F.2d 96, 99 (9th Cir. 1988) (as amended in 1989) (*per curiam*). In *Credit Managers Ass'n, supra*, the court, endorsing the regulations, explained that an employer "can establish an ERISA plan rather easily. Even if an employer does no more than arrange for a 'group-type insurance program,' it can establish an ERISA plan, unless it is a mere advertiser who makes *no* contributions on behalf of its employees. 29 C.F.R. § 2510.3-1(j)." 809 F.2d at 625.

A number of other lower federal and state courts, mirroring the sharp Circuit conflict, have recently added to the confusion and error begun by *Taggart Corp.* In *Pitre v. Louisiana Health Service and Indemnity Co.*, 122 F.R.D. 497, 499 (W.D. La. 1988), the district court, finding there was insufficient evidence on premium payment to determine ERISA coverage, nevertheless cited with approval the *Taggart Corp.* coverage requirement that the employer participate in plan administration. In *Sayble v. Blue Cross of Southern California*, 207 Cal. App.3d 953 (1989), the California court of appeal—notwithstanding the Ninth Circuit's clear pronouncements to the contrary—held that an employer's purchase of group health insurance and payment of monthly premiums did not establish an ERISA plan.[21] Overtly hos-

[20] The Third Circuit, in *Shiffler v. Equitable Life Assur. Soc. of U.S.*, 838 F.2d 78, 82 n.4 (3d Cir. 1988), also relying on the regulations, held that even where the employees pay the premiums for group insurance coverage, the plan is ERISA-covered if the employer endorses the plan or is involved in its administration.

[21] Compounding the confusion, the court granted rehearing evidently to resolve whether facts stipulated only to support the defendant's summary judgment motion could be used in support of the plaintiffs' cross-motion. (Order filed March 3, 1989).

tile to ERISA's principal goals, the court wrote that if such plans were ERISA-covered, "every garden variety employee health insurance plan" would be regulated by ERISA, thus "bind[ing] the insured employee to ERISA's remedies." *Id.* at 962. Following the *Taggart Corp.* rationale, the court held that an employer can only establish an ERISA plan by "[participating] in the administration of the . . . insurance benefit" through processing claims and keeping appropriate records to comply with ERISA's reporting requirements. *Id.*[22] *See also Jordan v. Reliable Life Ins. Co.*, 694 F.Supp. 822, 835 (N.D. Ala. 1988) (rejecting ERISA coverage and preemption as overly burdensome; "Only Congress or the Supreme Court can rescue us from the quicksand").

The Nevada Supreme Court's decision is a prime example of increasing division and error in the lower courts on ERISA's most basic issues of coverage and preemption, all stemming from an irreconcilable Circuit conflict. These decisions, to avoid ERISA preemption, overturn the statutory definition of "employee welfare benefit plan," and substitute a coverage test based on how a plan is funded or administered. If these rulings are allowed to prevail, the states will be able to reassert control over essentially all employee welfare benefit plans. In addition, employers will be able to evade ERISA's civil and criminal provisions simply by designating an insurer or a third party as plan administrator. Only a decision by this Court can reassert the uniform system of federal regulation over employee welfare benefit plans that Congress intended and that is now so obviously lacking across the country.

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[22] The California courts of appeal themselves are reaching inconsistent results on the ERISA coverage issue. *See e.g., Rizzi v. Blue Cross of Southern California*, 206 Cal.App.3d 380 (1988) (upholding ERISA coverage based on employer's purchase of insurance and payment of premiums).

III. The Nevada Supreme Court's Decision Takes An Intentional Step Backward From Pilot Life, Reopening A Door To Punitive Damages And Raising Financial Disincentives To Insured Plans Contrary To Congressional Intent.

The Nevada Supreme Court's decision takes an intentional step backward from this Court's recent decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), that ERISA provides an *exclusive* civil enforcement scheme in suits involving employee welfare benefit plans. By effectively repealing these civil enforcement provisions, the decision reopens a door to punitive damages twice closed by this Court in *Pilot Life* and *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 147 (1985). It also raises financial disincentives to insured plans contrary to congressional intent.

In *Pilot Life* and *Russell*, this Court, after analyses of ERISA's civil enforcement provisions and overall congressional purpose, held that the Act's civil enforcement scheme does not allow for any extracontractual relief, including punitive damages. *Pilot Life*, *supra*, 481 U.S. at 54; *Russell*, *supra*, 473 U.S. at 146. ERISA reflects a "balancing of policies" including the strong "public interest in encouraging the formation of . . . plans." *Pilot Life*, *supra*, 481 U.S. at 54. Congress, in addition, was "acutely aware" that the cost of financing a voluntary system of plans was "an important factor" in determining whether they will be adopted." 120 Cong. Rec. 29,952, 29,953 (1974) (remarks of Sen. Nelson). To promote this voluntary system of plans, Congress placed them all under an umbrella of federal regulation including internal procedures to resolve benefit disputes. *See* ERISA section 503, 29 U.S.C. § 1133. As this Court recognized, a "patch-work scheme of regulation would introduce considerable inefficiencies in benefit program operation," leading to a reduction in benefits, or to no plan at all. *Fort Halifax Packing Co. v. Coyne*, 107 S. Ct. 2211, 2217 (1987).

The Nevada Supreme Court's decision, by exposing employee welfare benefit plans and their fiduciaries to suits under state law, will lead to increased transaction costs and hence to a reduction in benefits, a self-funding of plans, or to their abandonment altogether.[23] This sharply clashes with Congress' intent as shown in section 89 of the Internal Revenue Code to expand the use of employer-sponsored health care plans to provide for the "well-being and security" [24] of the over 30 million Americans (one out of eight) without any coverage at all.[25]

IV. The Court's Alternative Holding That Working Owners Are Not Participants Or Beneficiaries For Purposes Of ERISA's Civil Enforcement Provisions Creates A Serious Dysfunction In The Statute, And Will Lead To The "Mutually Exclusive Pockets Of Federal And State Jurisdiction Within A Plan" Warned Against By This Court.

In its alternative holding, the Nevada Supreme Court addressed a second, major ERISA issue—whether working owners, partners or sole proprietors who, along with common law employees,[26] are covered by an ERISA plan, are "participants" or "beneficiaries" for purposes of ERISA's civil enforcement provisions. ERISA defines "participant" as the "employee" of any employer, and defines "beneficiary" as including "a person designated . . . by the terms of [a] plan, who is or may become eligible to receive benefits. . . ." [27]

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[23] *See amicus* brief filed by the Solicitor General, on behalf of the United States, at 7-8, in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).

[24] *See* ERISA section 2(a), 29 U.S.C. § 1001(a).

[25] *Statistical Abstract of the United States* (108th ed. 1988) 92.

[26] An ERISA plan must include at least *one* common law employee; if the only participants are owners, partners or sole proprietors there is no ERISA coverage. 29 C.F.R. § 2510.3-3(b) (1987); *see* DOL Opinion Letter 77-10.

Inclusion of these self-employed individuals in employee welfare benefit plans along with common law employees has long been standard practice—indeed, one approved by the National Association of Insurance Commissioners.[28] ERISA, moreover, covers the self-employed in its other regulatory provisions which govern participation and vesting, funding, fiduciary responsibility, and reporting and disclosure.[29] Congress most recently reconfirmed

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[27] ERISA defines a "participant" as "any employee of an employer . . . who is or may become eligible to receive a benefit . . . from an employee benefit plan. . . ." Section 3(7), 29 U.S.C. § 1002(7). "Beneficiary" is defined in Section 3(8), 29 U.S.C. § 1002(8).

[28] *See* N.A.I.C. Group Health Insurance Definition and Group Health Insurance Standard Provisions Model Act, Section 1 (eligible employees may include the employees of the employer's subsidiaries as well as an individual proprietor and partners of a partnership); Harnett and Lesnick, *The Law of Life and Health Insurance* (1988) § 9.01 [3]. *See also* Gregg, *Group Life Insurance* (1957 ed.) 28 ("Individual proprietors and partners are generally considered to be employees for group insurance purposes if they are actually engaged in the business.")

[29] *See* ERISA sections 101-111, 201-211, 401-414, 301-306, 29 U.S.C. §§ 1021-31, 1051-61, 1101-14, 1081-86; *see also* Department of Treasury, Department of Labor, and Pension Benefit Guaranty Corporation 1987 Instructions for Form 5500-C, No. 7 ("Active participants include any individuals who are currently in employment *(including self-employed)* covered by a plan and who are earning or retaining credited service under a plan" (emphasis added). As shown in the discussion of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and section 89 of the Internal Revenue Code, *infra*, Congress has consistently used the term "employee" in its broadest sense to include the working self-employed when both the self-employed and common law employees are covered by a welfare benefit plan. This reflects the common understanding of the term in the group insurance context. *See* Gregg, *Group Life Insurance* (1957 ed.) 28; Greider and Beadles, *Law and The Life Insurance Contract* (4th ed. 1979) 581. The Department of Labor regulations, by describing self-employed individuals as "participants," also demonstrate that where an ERISA plan covers both the self-employed and common law em-

its intent to include the working self-employed as ERISA "participants" and "beneficiaries" in its enactment of the satellite statute, COBRA, and section 89 of the Internal Revenue Code.[30]

At stake is whether suits by the self-employed for plan benefits and breaches of fiduciary duties will be governed by ERISA or by conflicting state law doctrines. This issue is one of extraordinary breadth over which

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ployees, the Act governs the rights of all participants. 29 C.F.R. § 2510.3-3(b) (1987). *See* DOL Reporting and Disclosure Regulations, 40 Fed. Reg. 34525, 34528 (August 15, 1975) (definition of "employee" in 29 C.F.R. § 2510.3-3 is for the limited purpose of determining whether a plan has any employees, and thus whether an ERISA plan exists; hence the regulations are revised to expressly limit the definition of "employee" to § 2510.3-3 in order to avoid excluding the "self-employed" from the definition of "participant" in ERISA section 3(7)). *See also* DOL Opinion Letters 79-8A and 81-54A; *Dodd v. John Hancock Mutual Life Ins. Co.*, 688 F.Supp. 564, 571-72 (E.D. Cal. 1988); *see also Ed Miniat, Inc. v. Globe Life Ins. Group, Inc.*, 805 F.2d 732, 740 n.14 (7th Cir. 1986), *cert. denied*, 107 S. Ct. 3188 (1987). In contrast, a sole proprietor who brings no covered employees to a union-sponsored health care plan is not an ERISA "participant." *Giardono v. Jones*, 1989 U.S. App. LEXIS 1499 (7th Cir., 1989) (the court erred, however, in assuming the restrictive definition of "employee" in § 2510.3-3 was intended to carry over to ERISA section 3(7)).

[30] Under COBRA, the working self-employed who are covered by group health care plans which include common law employees are treated as "participants" and "covered employees" entitled to the full spectrum of COBRA continuation requirements. *See* Proposed Treas. Reg. § 1.61-1 Q & A 16 (1987). Similarly, section 89, 26 U.S.C. § 89, includes 5% owners as "participants" and "highly compensated employees" under all of its nondiscrimination rules for group health care plans; these individuals must be treated as "participants" and "employees" on a non-discriminatory basis with "non-highly compensated" employees. Furthermore, both COBRA and section 89 encourage employers to consolidate and centralize plan administration through the use of a single benefit structure for all individuals covered by group health care plans. Kelly, *How will The Welfare Benefit Plan Nondiscrimination Rules Apply?*, The Journal of Taxation, August, 1988, 80-81.

the courts are reaching conflicting results.[31] It affects every business in which a self-employed individual, along with one or more common law employees, is covered by and eligible to receive benefits under an ERISA plan. This includes not only medical, accounting and legal partnerships and professional corporations nationwide, but also many hundreds of thousands of small and medium sized businesses across the country whether incorporated or not.

The Nevada Supreme Court, by excluding the working self-employed from ERISA's civil enforcement provisions, creates a serious dysfunction between ERISA's civil enforcement scheme and the rest of its regulatory provisions. This schism, moreover, will permit the individual participant to sue the plan fiduciaries, who are required to administer the entire plan in accordance with federal law, for alleged violations of state law—the very conflict that *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), was intended to resolve. The state high court's decision also undercuts Congress' central purpose of promoting a cost-effective private employee benefit plan system through uniform fiduciary standards and remedies to guard individual rights from administrative abuse, and a single regulatory framework to allow simplicity and "national uniformity" in plan administration, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 n. 20 (1983). Only the inclusion of working owners in ERISA's civil enforcement provisions will advance these important goals. It will ensure that all working individuals covered by ERISA plans be protected by exactly the same fiduciary standards and remedies regardless of whether a pension

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[31] *Compare Dodd v. John Hancock Mutual Life Ins. Co.*, 688 F.Supp. 564, 571-72 (E.D. Cal. 1988) (sole owner of corporation is employee participant under ERISA) with *Pitre v. Louisiana Health Service and Indemnity Co.*, 122 F.R.D. 497, 499 (W.D. La. 1988) (law firm partner is not participant under ERISA).

or welfare benefit plan is involved.[32] It will also make certain that all ERISA plans be administered under a uniform set of procedures governed by a single set of laws. *See Fort Halifax Packing Co. v. Coyne*, 107 S. Ct. 2211, 2217 (1987); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 107-08 (1983).

In summary, the Nevada Supreme Court's decision creates the "mutually exclusive pockets of federal and state jurisdiction within a plan," and the "conflicting and inconsistent State and local regulation" against which this Court warned in *Fort Halifax*, *supra*, 107 S. Ct. at 2217, and *Shaw*, *supra*, 463 U.S. at 99, 107-08 (1983). If the decision is permitted to stand, Petitioners will be required to process Turnbow's benefit claims under state law, and the claims of all other participants under federal law—even if these laws require different results and impose vastly different remedies. Furthermore, to allow state law to govern Turnbow's claim of excessive premium

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[32] In a qualified retirement plan, ERISA treats self-employed individuals as employees for substantially all plan purposes, including participation. Any disparate treatment of self-employed individuals and common law employees between Title I (Protection of Employee Benefit Rights) and Title II (Amendments to the Internal Revenue Code Relating to Retirement Plans) of ERISA is plainly unwarranted in light of the fact that some plans are *both* welfare and pension plans (*see* ERISA section 3(3)), Congress' enactment of COBRA and Internal Revenue Code section 89, discussed *supra*, and its recognition of the need for "parity" between corporate and noncorporate plans reflected in the Tax Equity and Fiscal Responsibility Act of 1984 ("TEFRA"). *See RIA Employment Coordinator*, ¶ B-10,103 (Current Matter, Jan. 1989); Treas. Reg. § 1.162-26, Q & A 16 (1987); S. Rep. No. 494, 97th Cong., 2d Sess. 314, *reprinted in* 1982 U.S. Code Cong. & Admin. News 781, 1055; H. Con. Rep. No. 760, 97th Cong., 2d Sess. 620, *reprinted in* 1982 U.S. Code Cong. & Admin. News 1190, 1392. This Court, moreover, in construing ERISA's civil enforcement provisions recently disapproved of distinctions between funded and unfunded plans, at least with respect to the appropriate standard of judicial review of benefit determinations, in *Firestone Tire and Rubber Co. v. Bruch*, 57 U.S.L.W. 4194, 4198 (1989).

charges will not only cause an irreconcilable federal-state conflict over premium levels for the plan as a whole, but will permit the states to usurp the federal court's exclusive jurisdiction over ERISA's fiduciary standards and prohibited transaction rules. Such multiplicity of regulation and open-ended administrative and financial burdens were precisely the problems that ERISA was intended to avoid. *Fort Halifax Packing Co. v. Coyne*, 107 S. Ct. 2211, 2217 (1987).

Review of the Nevada Supreme Court's decision is essential to resolve the pervasive and unsettled issues of "participant" and "beneficiary" status. Failure to do so now will only add to the statutory dysfunction, and the "mutually exclusive pockets" of federal and state jurisdiction and "conflicting and inconsistent . . . regulation" proscribed in *Fort Halifax*, *supra*, and *Shaw*, *supra*.

V. The Questions Presented By This Petition Hold Important Implications For Employee Welfare Benefit Plans That Should Be Resolved By This Court.

The Nevada Supreme Court's decision undoubtedly poses a serious threat to Congress' twin goals of broad ERISA plan coverage and preemption, goals designed to encourage the growth and development of a private system of employee welfare benefit plans.

Over 145 million working Americans and their dependents are covered by employer or union-sponsored health care plans.[33] Moreover, of the estimated 4.5 million employer-sponsored health care plans,[34] the overwhelming majority are insured plans of the garden variety type. A recent study shows that 84% of employer-

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[33] *Statistical Abstract of the United States* (108th ed. 1988) 92.

[34] *Administration of the Employee Retirement Income Security Act, Calendar Year 1987, Report of the Secretary of Labor to Congress* i.

sponsored health care plans are insured or are self-funded with stop-loss coverage; for smaller employers, the figure rises to 95%.[35] Furthermore, 93% of *all* employers, self-funded and insured alike, delegate claims administration to an insurer or third-party administrator.[36]

The sponsors and administrators of these employee welfare benefit plans are required to make decisions on a daily basis regarding the continued existence of plans, the source of funding, the allocation of administrative duties, compliance with federal and state laws, "participant" and "beneficiary" coverage, and the processing and payment of claims. These decisions affect literally tens of millions of participants and beneficiaries. In addition, many of these plans are administered on a multi-state basis.

A dispositive decision by this Court is necessary to give practical guidance to sponsors and administrators on two of the most fundamental but increasingly unsettled ERISA issues—what is an "employee welfare benefit plan," and whether working owners, if covered by ERISA plans, are "participants" and "beneficiaries" for civil enforcement purposes. As shown by the sharp Circuit division and conflicting lower court cases, swift intervention by this Court is essential to restore Congress' carefully crafted balance between federal and state law, and to reestablish ERISA's preeminence over *all* employee welfare benefit plans.

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[35] *1988 Foster Higgins Survey* 23. *See also Battelle Study* 44 (99% of small employer health care plans (fewer than 100 employees) are insured; 92% of large plans (100 or more employees) are insured).

[36] *1988 Foster Higgins Survey* 24. Even for employers who self-fund their health care plans, 89% delegate claims administration. *Id. See also Battelle Study* 44 (99% of small employer health care plans, and 92% of large employer plans, delegate claims administration to an insurer).

CONCLUSION

For the foregoing reasons, a writ of certiorari should issue to review the judgment and opinion of the Nevada Supreme Court.

Respectfully submitted,

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March 20, 1989

APPENDIX

IN THE SUPREME COURT OF THE
STATE OF NEVADA

No. 18516

HARRIETTE TURNBOW,

Appellant,

v.

PACIFIC MUTUAL LIFE INSURANCE COMPANY, a California Corporation; PENSION ADMINISTRATION, INC., a California Corporation; JOHN F. MCGOWAN, Individually, DONALD R. LAWRENZ, Individually and as Trustee for Beneficial Employees Security Trust; BENEFICIAL EMPLOYEES SECURITY TRUST,

Respondents.

December 21, 1988

Appeal from an order granting respondents summary judgment. First Judicial District Court, Carson City; Michael R. Griffin, Judge.

Reversed.

Riley Beckett and *Carl F. Martillaro*, Carson City, for Appellant.

Hawkins & Sharp and *Keegan G. Low*, Reno, for Respondents.

OPINION

Per Curiam:

On November 1, 1974, appellant, Harriette Turnbow, dba The Bottle Stop, subscribed to respondent Beneficial Employees Security Trust (BEST). Appellant is the sole

owner of "The Bottle Stop," a liquor store in Yerington. BEST is a multi-employer trust (MET), underwritten by respondent Pacific Mutual Insurance Company. A MET is a trust created to pool small employers together to permit them to obtain lower insurance rates.

By subscribing to BEST appellant was able to obtain major medical insurance benefits up to $1,000,000. Appellant paid the premiums through The Bottle Stop. The policy provided coverage for appellant and three full-time employees of The Bottle Stop.

In August, 1981, appellant suffered a stroke. Appellant received benefits under the policy. However, by May of 1983 the monthly premium had risen to $1,256.00. Appellant could no longer afford the premium payments and lost her benefits under the policy.

On July 15, 1985, appellant filed suit in the First Judicial District Court. Appellant sought insurance proceeds and damages under several different theories including: breach of contract, bad faith, breach of the insurance companies' obligations under NRS 686A.010 *et seq.*, infliction of emotional distress and punitive damages. Respondents removed the suit to federal district court. Subsequently, the case was remanded back to the First Judicial District Court.

Respondents moved to dismiss the action. Respondents asserted that appellant had created an ERISA plan and that appellant's causes of action were therefore preempted by federal law.[1] Appellant opposed the motion contending that she had not created an ERISA plan. The district court treated the motion to dismiss as a motion for summary judgment. The district court granted respondents' motion finding that appellant had created an ERISA plan and that federal law preempted her causes of action under state law. This appeal followed.

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[1] Employees Retirement Income Security Act of 1974, U.S.C. §§ 1001 *et seq.*

Appellant contends that the district court erred in granting respondents summary judgment. Specifically, appellant contends that the district court erred in determining that she had created an ERISA plan.

There are two leading cases on the issue of whether an employer can create an ERISA plan merely by purchasing health insurance benefits for employees. One is Donovan v. Dillingham, 688 F.2d 1367 (11th Cir. 1982) and the other is Taggart Corp. v. Life and Health Benefits Administration, Inc., 617 F.2d 1208 (5th Cir. 1980). Both cases indicate that more is involved in creating an ERISA plan than the mere purchase of health insurance benefits for employees by an employer.

The court in *Dillingham* held that employers who subscribed to METS pursuant to collective bargaining agreements or pursuant to a continuing practice of purchasing insurance for a class of employees had established employee welfare plans. *Dillingham*, 688 F.2d at 1374. The *Dillingham* court also held that those employers subscribing to a MET, although not pursuant to collective bargaining agreements or a practice of providing insurance benefits, also established employee welfare plans if circumstances showed an anticipated continued furnishing of the benefits. *Dillingham*, 688 F.2d at 1374, 1375. Thus, *Dillingham* requires, in addition to the employer purchasing health insurance benefits for employees, that circumstances indicate the employer is committed to the continuation of health insurance benefits for employees.

The *Taggart* court held that an employer did not establish an ERISA plan by subscribing to a MET. *Taggart*, 617 F.2d at 1211. The *Taggart* court stated: "[W]e cannot believe that [ERISA] regulates bare purchases of health insurance where, as here, the purchasing employer neither directly nor indirectly owns, controls, administers or assumes responsibility for the policy or its benefits." *Taggart*, 617 F.2d at 1211. The *Taggart* court reasoned that ERISA had been created to protect the

assets of employee benefit plans and that because there were no assets and the employer was not liable for benefits no plan existed. *Taggart*, 617 F.2d at 1211. Thus, *Taggart* also requires, in addition to the employer purchasing health insurance benefits for employees, that some indication exists showing the employer intended to guarantee the continuation of health insurance benefits for employees.

We conclude that the district court erred in finding that appellant had created an ERISA plan. Appellant did not create an ERISA plan. Unless there is some indication that an employer is committed to or has guaranteed the continuation of such benefits, nothing is created for ERISA to protect and no plan exists. Appellant did not purchase the health insurance for her employees pursuant to a collective bargaining agreement or a practice of providing such benefits. Nor is there any indication that appellant intended to guarantee the continued furnishing of the benefits. ERISA dos not regulate the bare purchases of health insurance where, as here, there is no indication that the employer intended to guarantee the continued furnishing of the benefits.

Appellant also contends that the district court erred in determining that her state common law claims were preempted by ERISA. The United States Supreme Court has held that when an ERISA plan exists state common law remedies are preempted by the remedies provided under ERISA. Pilot Life Insurance Co. v. Dedeaux, 481 U.S. ——, 107 S.Ct. 1549 (1987). As we stated above, appellant did not create an ERISA plan. Therefore, her state common law remedies were not preempted and the district court erred in determining that they were.

Furthermore, appellant does not qualify as a participant or beneficiary in an ERISA plan within the meaning of ERISA and therefore may seek relief under our state common law.

> In order for an individual to bring an action to recover benefits owed under an ERISA plan, the individual must be a "participant" or "beneficiary" of the plan. *See* 29 U.S.C. § 1132(a)(1)(B). Conversely, if [appellant] is not a "participant" or "beneficiary," [she] may sue under and seek the broader relief provided by state tort law, and the case must be remanded to state court to permit [her] to do so.

Dodd v. John Hancock Mut. Life Ins. Co., 688 F.Supp. 564, 568 (E.D.Cal. 1988). Appellant was a participant or beneficiary in an ERISA plan only if she was an employee. *Dodd*, 688 F.Supp. at 569.

Dodd held that "an owner of a corporation who is also an employee of the corporation shall be treated as an employee for purposes of determining whether the owner is a participant in such a plan within the meaning of ERISA." *Dodd*, 688 F.Supp. at 571. The *Dodd* court reasoned that when self-employed individuals incorporate the corporation becomes the employer and the most natural reading of the statute includes all corporate employees as employees under an ERISA plan. In this case, appellant was self-employed. Her business, The Bottle Stop, was not incorporated and therefore could not be considered appellant's employer. Thus, even if appellant could be viewed as having created an ERISA plan, she was not an employee and is entitled to seek relief in state court. Accordingly, we reverse and remand this case to the district court so that appellant may proceed to trial on all her causes of action.[2]

YOUNG, A. C. J.
STEFFEN, J.
SPRINGER, J.
MOWBRAY, J.

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[2] THE HONORABLE E. M. GUNDERSON, Chief Justice, did not participate in the decision of this appeal.

IN THE FIRST JUDICIAL DISTRICT COURT
OF THE STATE OF NEVADA
IN AND FOR CARSON CITY

Case No. 85-01107A

Dept. No. 1

HARRIETTE TURNBOW,
Plaintiff,

v.

PACIFIC MUTUAL LIFE INSURANCE COMPANY, a California corporation; BENEFICIAL ADMINISTRATION COMPANY, a California corporation; PENSION ADMINISTRATION, INC., a California corporation, DONALD R. LAWRENZ, individually and as TRUSTEE for BENEFICIAL EMPLOYEES SECURITY TRUST, BENEFICIAL EMPLOYEES SECURITY TRUST, and DOES I THROUGH L, inclusive,
Defendants.

ORDER GRANTING SUMMARY JUDGMENT

The issue before the court is whether the Plaintiff created an ERISA plan when she procured insurance for herself, her daughter, and her employees of The Bottle Stop.

In order to have an ERISA plan, several elements must be present:

1. The employer must endorse the insurance program, not merely advertise;
2. The employer must make contributions;
3. The employees must participate automatically in the plan provided they meet the requirements for the program;

4. The employer must receive consideration in connection with the program over and above a fee for its administrative expenses actually rendered in connection with payroll deductions or dues checkoffs. 29 C.F.R. Sec. 2510.3-1(j).

In the present situation, Plaintiff procured insurance under the name "The Bottle Stop" for herself, her daughter, and her full-time employees. Therefore, she did not merely advertise the insurance program.

Additionally, The Bottle Stop paid the premiums for the employee insurance through the company account. There was no evidence presented showing any employee contribution towards the payment of those premiums.

Also, The Bottle Stop, through its owner, procured the insurance for the benefit of all its full-time employees. Participation of those employees was automatic.

Conclusively, the Plaintiff established an ERISA plan knowingly or unknowingly.

Federal law will preempt any State Court action based upon the causes of action stated.

THEREFORE, it is ordered that the Motion for Summary Judgment is granted without prejudice.

DONE this 11th day of AUGUST, 1987.

/s/ Michael R. Griffin
District Judge

IN THE FIRST JUDICIAL DISTRICT COURT
OF THE STATE OF NEVADA
IN AND FOR CARSON CITY

Case No. 85-01107A

HARRIETTE TURNBOW,
Plaintiff,

v.

PACIFIC MUTUAL LIFE INSURANCE COMPANY, a California corporation; BENEFICIAL ADMINISTRATION COMPANY, a California corporation; PENSION ADMINISTRATORS, INC., a California corporation; JOHN F. MCGOWAN, individually; DONALD R. LAWRENZ, individually and as TRUSTEE for BENEFICIAL EMPLOYEES SECURITY TRUST; BENEFICIAL EMPLOYEES SECURITY TRUST; and DOES I THROUGH L, inclusive, *Defendants.*

ORDER

The court having reviewed Plaintiff's Motion for Reconsideration and for Leave to Amend and the Opposition thereto and good cause appearing:

IT IS HEREBY ORDERED that the Plaintiff's Motion for Reconsideration is denied. Plaintiff's Alternate Motion for Leave to Amend is also denied.

Moving Defendant's request that this Court's Order granting Summary Judgment, dated August 11, 1987, be amended and clarified, nunc pro tunc, is hereby granted and that Order is therefore amended at line 21, page 1 to add the words "one of" so that the sentence in question shall hereafter read "In order to have an ERISA plan, one of several elements must be present:".

Dated this 14th day of September, 1987.

/s/ Michael R. Griffin
District Court Judge

STATUTORY PROVISIONS

Employee Retirement Income Security Act of 1974, as amended.

1. Sections 3(1), (7) and (8), 29 U.S.C. §§ 1002(1), (7) and (8). Definitions.

§ 1002. Definitions

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

* * * *

(7) The term "participant" means any employee or former employee of an employer, or any member or former member of an employee organization, who is or may become eligible to receive a benefit of any type from an employee benefit plan which covers employees of such employer or members of such organization, or whose beneficiaries may be eligible to receive any such benefit.

(8) The term "beneficiary" means a person designated by a participant, or by the terms of an em-

ployee benefit plan, who is or may become entitled to a benefit thereunder.

2. Section 502(a), 29 U.S.C. § 1132(a). Civil Enforcement.

§ 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provisions of this subchapter or the terms of the plan;

(4) by the Secretary, or by a participant, or beneficiary for appropriate relief in the case of a violation of 1025(c) of this title;

(5) except as otherwise provided in subsection (b) of this section, by the Secretary (A) to enjoin any act or practice which violates any provision of this subchapter, or (B) to obtain other appropriate equitable relief (i) to redress such violation or (ii) to enforce any provision of this subchapter; or

(6) by the Secretary to collect any civil penalty under subsection (i) of this section.

3. Section 505, 29 U.S.C. § 1135. Regulations.

§ 1135. Regulations

Subject to subchapter II of this chapter and section 1029 of this title, the Secretary may prescribe such regulations as he finds necessary or appropriate to carry out the provisions of this subchapter. Among other things, such regulations may define accounting, technical and trade terms used in such provisions; may prescribe forms; and may provide for the keeping of books and records, and for the inspection of such books and records (subject to section 1134(a) and (b) of this title).

4. Section 514(a), 29 U.S.C. § 1144a. Effect on other laws.

§ 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

Regulations promulgated under Section 503 of ERISA, 29 U.S.C. 1133

1. 29 C.F.R. § 2510.3-1(j) (1987).

(j) *Certain group or group-type insurance programs.* For purposes of Title I of the Act and this chapter, the terms "employee welfare benefit plan" and "welfare plan" shall not include a group or group-type insurance pro-

gram offered by an insurer to employees or members of an employee organization, under which

(1) No contributions are made by an employer or employee organization;

(2) Participation in the program is completely voluntary for employees or members;

(3) The sole functions of the employer or employee organization with respect to the program are, without endorsing the program, to permit the insurer to publicize the program to employees or members, to collect premiums through payroll deductions or dues checkoffs and to remit them to the insurer; and

(4) The employer or employee organization receives no consideration in the form of cash or otherwise in connection with the program, other than reasonable compensation, excluding any profit, for administrative services actually rendered in connection with payroll deductions or dues checkoffs.

2. 29 C.F.R. § 2560.503-1(g)(2) (1987).

(2) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such company, service or organization. In such case, that company, service, or organization shall be the "appropriate named fiduciary" for purposes of this section. In all other cases, the "appropriate named fiduciary" for purposes of this section may be the plan administrator or any other person designated by the plan, provided that such plan administrator or other person is either named in the plan instrument or is identified pursuant to a procedure set forth in the plan as the person who reviews and makes decisions on claim denials.

Supreme Court, U.S.
FILED
MAY 12 1989
JOSEPH F. SPANIOL, JR.
CLERK

No. 88-1546

In The

Supreme Court of the United States

October Term, 1988

PACIFIC MUTUAL LIFE INSURANCE COMPANY, et al.,

Petitioners,

v.

HARRIETTE TURNBOW,

Respondent.

Petition For Writ Of Certiorari To The Supreme Court Of Nevada

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OPINION BELOW

The opinion of the Supreme Court of Nevada is reported at 104 Nev Adv Op 109 and 765 P.2d 1160 (1988).

STATEMENT OF THE CASE

A. The Facts

HARRIETTE TURNBOW ("TURNBOW"), is a sole proprietor of a retail liquor store and business in Yerington, Nevada, known as "The Bottle Stop". In 1974 she decided to obtain comprehensive major medical insurance primarily for her and her daughter Yvonne Rotchy. She consulted with her insurance agent John F. McGowan ("MCGOWAN") and he recommended and she purchased the *"American Series Plan"* of a comprehensive major medical insurance issued under the name of B.E.S.T., an acronym for Beneficial Employees Security Trust. The original booklet describing her health insurance defined a "Subscribing Employer is an employer that has two or more eligible employees and that subscribes to the trust agreement providing this insurance".

The *American Series Plan* of B.E.S.T. health insurance is a multiple employer trust known in the insurance industry as a "MET". MET's are an insurance vehicle which offers employers with small groups of employees (usually under ten) the opportunity to obtain health insurance benefits at group rates by pooling these employees and then presenting them to an insurance

company as a large group.[1] In this case the B.E.S.T. plans were underwritten and claims were paid by Pacific Mutual Life Insurance Company.

The B.E.S.T. policy provided that TURNBOW had $1,000,000.00 worth of comprehensive major medical coverage with a $200.00 per year deductible. TURNBOW faithfully paid her insurance premiums from November 1, 1974 until August, 1981 with the premiums remaining relatively stable during that seven (7) year period.

In August, 1981 TURNBOW suffered a major stroke, the results of which today she is considered permanently and totally disabled. She has been and is currently institutionalized at the Lyon County Health Center in Yerington, Nevada.

Shortly after TURNBOW suffered her stroke and submitted claims, the premiums on her B.E.S.T. health policy began to dramatically increase; to-wit, in less than a year and one half the premiums rose in excess of 372% from $190.00 per month to $1,256.00 per month. In April and May, 1983, TURNBOW's daughter Yvonne Rotchy received notification from B.E.S.T. that there would be further premium increases that would occur at an accelerated rate. Rotchy understood the premium was going to double from $1,256.00 per month to approximately $2,500.00 per month. Rotchy contacted MCGOWAN informing him that TURNBOW could no longer afford to pay

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[1] Please note that multiple employer trusts [MET's] are not in any way related to the term multiemployer plans, funds or programs described in ERISA; those plans, funds or programs concern union members who typically work for several employers during the course of a year.

those premiums and inquired as to what action to take. As a result of her discussions with MCGOWAN no further premiums were paid from May, 1983 on. The medical, hospital, convalescent and other health providers expenditures which previously had been covered by B.E.S.T. became so excessive it financially destroyed TURNBOW and her business "The Bottle Stop".

The gravamen of TURNBOW'S position is that she was to receive $1,000,000.00 in benefits. B.E.S.T. cut off her benefits after paying approximately $46,000.00, assigning as a cause for termination of the benefits that she had to receive all benefits she was entitled within a two-year period, according to the insurance policy. TURNBOW maintains that no such provision was contained in the "brochure" which induced her to purchase the insurance, and, even if the insurance contract contained such language, it was ambiguous.

B.E.S.T. and PACIFIC MUTUAL also embarked on a course of *"creaming"* the good risks in the *American Series Plan*. The *American Series Plan* was operating under a California trust. B.E.S.T. and Pacific Mutual set up a competing trust in Missouri naming that B.E.S.T's *Preferred Series Plan*. B.E.S.T. then actively solicited from insureds in the *American Series Plan* seeking them to switch from the *American Series Plan* to the *Preferred Series Plan*.

"Creaming" is an actuarial term whereby an insurance company entices or removes the healthy people or good insurance risks out of the insurance pool thus leaving only the sick insured or bad insurance risks in the plan. As is obvious, with only sick insureds and bad risks in

the remaining insurance pool the premiums rise geometrically and self-destructs when those remaining insureds cannot afford the premiums.

TURNBOW, with her pre-existing stroke and related medical problems, was ineligible to transfer to the *Preferred Series Plan* and ultimately failed to pay premiums and lost her coverage under the existing *American Series Plan*.

TURNBOW also takes the position that her rights vested when she was felled by her stroke (her policy was in good standing at that time). B.E.S.T., in addition to the reason that TURNBOW must receive her $1,000,000.00 in benefits within a two-year period, also assigned as a reason for cancellation the failure to pay the phenomenal increase in premiums.

B. Procedural History

This matter was originally filed in the First Judicial District Court of Nevada and was subsequently removed by Petitioners to Nevada Federal District Court (Case No. CV-R-85-427-ECR). During the course of discovery it was discovered that B.E.S.T., in coordination with Pacific Mutual, was an umbrella of eight (8) separate entities and were all controlled by the trustee of B.E.S.T. Mr. Donald R. Lawrenz, his family or his partners; those eight (8) entities being:[2]

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[2] Please note that petitioners, for the first time during this litigation, as mandated by Rule 28.1, revealed two (2) more subsidiaries and affiliates, those being BEST Pro-tec, Inc., and BEST Benefit Payment, Inc., not previously disclosed to Respondent.

FOUR MULTI-EMPLOYER TRUSTS

1. California Trust
2. Missouri-Nationwide Trust
3. Missouri-New York Trust
4. Utah Trust

BENEFICIAL ADMINISTRATION COMPANY

a California Company that was in charge of the administration of the claims.

PENSION ADMINISTRATORS INC.

a California Corporation in charge of marketing and promotional matters.

B.E.S.T. LIFE ASSURANCE COMPANY OF CALIFORNIA

a reinsurance company for B.E.S.T. that works in conjunction with PACIFIC MUTUAL in underwriting the policies.

B.E.S.T. EMPLOYERS ASSOCIATION, INC.

a mandatory non-profit association that assessed fees on each of the employers and lobbied for and sent out material of concern to subscribing employers.

On February 3, 1987 TURNBOW, through discovery, found additional defendants and moved to amend her complaint bringing in JOHN C. MCGOWAN and PENSION ADMINISTRATORS INC. U. S. District Judge Edward Reed granted the Motion To Amend Complaint and remanded the case back to the Nevada First Judicial District Court.

C. Trial Court Dismissed Case Based On Erisa Preemption

On the same day, as the First Amended Complaint was filed, Petitioners moved to dismiss the action based on the fact that the Employee Retirement Income Security Act of 1974 ("ERISA") preempted TURNBOW's causes of action. This was the first time that ERISA had been brought up during the over two years of litigation.

After being briefed and argued, District Judge Michael R. Griffin treated the motion to dismiss as a motion for summary judgment and granted the motion without prejudice. TURNBOW moved to reconsider or in the alternative to allow her to amend the complaint to assert an ERISA cause of action or to have the case remanded back to the Federal Court. The judge denied that motion to reconsider which effectively dismissed TURNBOW's complaint with prejudice.

D. Nevada Supreme Court Unanimously Reverses

TURNBOW appealed both the Order Granting Summary Judgment and Order denying her Motion For Reconsideration to the Nevada Supreme Court. Both of those Orders are attached to Petitioner's Appendix at Pg 6a-7a and 8a respectively.

The Supreme Court of Nevada properly reversed the District Court holding that *employee welfare benefit plan* under ERISA had not been created and that TURNBOW did not qualify as a participant or beneficiary in an ERISA plan within the meaning of ERISA.

REASONS FOR DENYING THE WRIT

1. Recent Case Of Morash Is Dispositive Of Issue

Petitioner's try and paint a picture of circuits in disarray, congressional intent violated and State Courts attempting to circumvent this Court's holding in *Pilot Life Ins. Co. v. Dedeaux*, 481 US 41 (1987), that simply is not the case.

On April 18, 1989 this Court in *Massachusetts v. Morash* ___US___, 57 Law Week 4429, 49 CCH S.Ct. Bull pg B2095 (No 88-32) construed that unused vacation time does not constitute an *employee welfare benefit plan* within the meaning of ERISA. This Court looked to the whole of the ERISA act stating:

> 'that in expounding a statute, we [are] not . . . guided by a single sentence or member of a sentence, but look to the provisions of the whole law, and to its object and policy'. Pilot Life Insurance Co. v. Dedeaux, 481 U. S. 41, 51 (1987). *In enacting ERISA, Congress' primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees benefits from accumulated funds.* California Hospital Assn., supra, at 859. To that end, it established extensive reporting disclosure, and fiduciary duty requirements to insure against the possibility that the employee's expectation of the benefit would be defeated through poor management by the plan administrator. Because ordinary vacation payments are typically fixed, due at known times, and do not depend on contingencies outside the employee's control, they *present none of the risks that ERISA is intended to address.* If there is a danger of defeated expectations, it is not different from the danger of defeated expectations of wages for services performed – a danger Congress chose not to regulate in ERISA. (emphasis added)

Like unused vacation pay the bare purchase of health insurance especially by a sole proprietor of a business does not by itself constitute an ERISA plan.

Petitioners make reference to *Fort Halifax Packing Co v. Coyne* 482 US 1 (1987) stating that ERISA was intended by Congress to replace a patchwork of state and local rules concerning employee benefit plans. This Court's latest admonition expressed in *Massachusetts v. Morash*, supra states:

> "Absent any indication that Congress intended such far-reaching consequences, we are reluctant to so significantly interfere with 'the separate spheres of governmental authority preserved in our federalist system.' " id at 49 CCH S.Ct Bull Pg. B2108.

Per *Morash*, ERISA cannot interfere with state law unless the object of that inference is a risk or danger to employees which Congress intended to address. In this case at bar, TURNBOW is the owner and procurer of the very health insurance policy in question. Congress never intended to extend ERISA coverage to a sole proprietor who merely purchased health insurance. For this Court to say "yes", there is, ERISA coverage on the bare purchase of health insurance would put employers throughout the United States to the choice of complying with the statute's detailed requirements for reporting and disclosing or not buying health insurance for their employees.

2. Case Turned On Own Facts; Affect Few Litigants.

The Nevada Supreme Court in making its ruling had to rely upon the record made by the district court on its summary judgment ruling. No trial has occurred in the

underlying action. No finder of fact has made any determination of what TURNBOW intended when she purchased health insurance for her and her daughter.

The Nevada Supreme Court decision does not attempt to deviate from central holding of *Pilot Life Ins. Co. v. Dedeaux* 481 US 41 (1987). Viewed in its most common denominator the Nevada Supreme Court says that ERISA does not apply to the bare purchase of group health insurance by an aggrieved sole proprietor of a business. That effects few litigants contrary to petitioners expansive claims.

CONCLUSION

For the forgoing reasons the petition for a writ of certiorari should be denied.

Respectfully Submitted,

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MOTION FILED
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No. 88-1546

IN THE
Supreme Court of the United States
OCTOBER TERM, 1988

PACIFIC MUTUAL LIFE INSURANCE COMPANY, *et al.*,
Petitioners,

v.

HARRIETTE TURNBOW,
Respondent.

On Petition for Writ of Certiorari to the Supreme Court of Nevada

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE* OF UNUM LIFE INSURANCE CO. IN SUPPORT OF PETITIONER

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HARRIETTE TURNBOW,
Respondent.

On Petition for Writ of Certiorari to the Supreme Court of Nevada

---

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE*

UNUM Life Insurance Company ("UNUM") hereby respectfully moves for leave to file the attached brief *amicus curiae*. The attorney for petitioners has consented; the attorney for respondent has refused consent.

UNUM and its affiliates [1] sell and service employee welfare benefit plan insurance in all 50 states and the District of Columbia, and insure more employer-sponsored long term disability plans (over 25,000) with a greater number of insured employee participants (2,919,872) [2] than any other insurer in the United States.[3] UNUM also insures over 8,000 group-employer sponsored life and

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[1] UNUM Life Insurance Company of America and First UNUM Life Insurance Company of New York, formerly known as Union Mutual Stock Life Insurance Co. of America and Unionmutual Stock Life Insurance Co. of New York, respectively.

[2] As of December 31, 1988.

[3] *Employee Benefits Plan Review*, April, 1987.

health insurance plans. UNUM group policies insure 3,102 employer-established and maintained benefit plans issued through 29 multiple employer trusts ("METs"), which make insured benefits available to employees of small employers at lower, affordable rates.

The questions presented in the instant case are of great importance to UNUM and to every other insurer that issues insurance to employee welfare plans. As an ERISA claims fiduciary for many of the employee welfare benefit plans it insures nationwide, UNUM's claim practices with respect to its employee benefit plan insurance are subject to federal regulation under ERISA.

The decision of the Nevada Supreme Court will have substantial adverse consequences for UNUM, other insurers of employee welfare plans, multi-employer trusts and other instrumentalities providing coverage for employee welfare plans, as well as for ERISA plan participants and beneficiaries. Because of its extensive experience and involvement with ERISA plans, UNUM is uniquely situated to advise the Court of the far-reaching consequences of the Nevada Supreme Court's decision in this case.

For the foregoing reasons, UNUM Life Insurance Co. respectfully urges the Court to accept and file the enclosed brief *amicus curiae*.

Respectfully submitted,

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IN THE

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On Petition for Writ of Certiorari to the Supreme Court of Nevada

---

BRIEF *AMICUS CURIAE* OF UNUM LIFE INSURANCE COMPANY

INTEREST OF *AMICUS*

The interest of *amicus* UNUM Life Insurance Co. is set forth in the accompanying motion for leave to file brief *amicus curiae*.

INTRODUCTION AND SUMMARY OF ARGUMENT

In *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), this Court made clear that Congress intended all suits brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated health insurance plans to be treated as federal questions governed by § 502(a), 29 U.S.C. § 1132(a).[1] Congress and the Court expected that a federal common law of rights and obligations under ERISA-regulated plans

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[1] 481 U.S. at 56.

would develop.[2] Congress' intent was manifest in the broad pre-emptive provisions it included in ERISA.

In *Pilot Life* as in other pre-emption cases resolved by this Court,[3] there was no doubt that the defendant plan and the plaintiff participant or beneficiary were subject to ERISA. The cases instead concerned various consequences that flowed from ERISA coverage. In each of these cases, the Court recognized the broad sweep Congress intended to give federal principles in the area of employee benefits.

In this case an insured covered by employer-provided group health insurance sought to persuade a court that she is entitled to pursue state law remedies, including punitive damages, in a suit against her insurer for improper administration of her insurance coverage. She could no longer assert that her right to state law remedies survives within ERISA—that legal claim was effectively foreclosed by this Court's decision in *Pilot Life*. Instead, the plaintiff urged two even more fundamental objections to ERISA pre-emption of her state law claims: (1) that her employer-funded group insurance was not an "employee welfare benefit plan" as that phrase is used in ERISA, because the plan documents lack "some indication that [the] employer is committed to or has guaranteed the continuation of such benefits" (Cert. Pet. at 4a); and (2) that as the owner-operator of her unincorporated business, she was not a plan "participant" as that term is used in ERISA, and so not subject to the statute. The Nevada Supreme Court, reversing the deci-

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[2] *Id.*

[3] *E.g., Mackey v. Lanier Collections Agency & Service, Inc.*, —— U.S. ——, 108 S. Ct. 2182 (1988); *Metropolitan Life Insurance Co. v. Taylor*, 481 U.S. 58 (1987); *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134 (1985); *Alessi v. Raybestos—Manhattan, Inc.*, 451 U.S. 504 (1981); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983).

sion of the trial court, accepted both of the claimant's arguments.

In *Pilot Life* this Court stressed the importance Congress placed on uniformity of standards in all aspects of group employee health and welfare insurance provided through employee benefit plans. The centerpiece of Congress' plan to achieve such uniformity was the preemption provisions of ERISA. The Nevada Supreme Court has undermined this Congressional plan by creating unique standards for determining what is a plan and who is a plan beneficiary. As a result, the federal interest in uniform application of the law has been thwarted. Point I(A).

In particular, the Nevada Supreme Court has imposed a "guarantee of continued benefits" standard that is a required feature of employee *pension* plans, but has not heretofore been considered a requirement of employee health and welfare plans. This requirement is not found in the words of ERISA, or in the Department of Labor regulations interpreting the statute. The legitimacy of this new requirement raises an important issue of federal law requiring the review of this Court. Point I(B).

The Nevada Supreme Court has held alternately that a self-employed owner-operator who is listed in the plan as a beneficiary along with her employees is not a plan participant covered by ERISA. In so ruling, the court rejected the Department of Labor's understanding of the status of such owner-operators. As a result of the court's ruling, owner-operators have all of the benefits of ERISA as a result of plan and insurer compliance with Department of Labor regulations, while those providing the plan benefits gain none of the certainty and uniformity envisioned by ERISA's sponsors and lose the statute's preemption of state causes of action. Congress could not have intended such an anomalous result, and only this Court can resolve this inconsistency. This Court there-

fore should review this important question of federal law. Point I(C).

The decision of the Nevada Supreme Court is in conflict with the decisions of four United States Courts of Appeals, and involves an area of ERISA law that is in a state of general confusion. This Court should review this matter to resolve this conflict. Point II(A).

Inconsistent understanding of crucial underlying ERISA concepts such as the definition of a "plan" and a "participant" strike at the heart of the uniform administration of employee benefit plans. Nevada's definition of "plan," moreover, invites employers to attempt to avoid ERISA compliance. Clarification of these central statutory terms is urgently needed. Point II(B).

ARGUMENT

I. THIS COURT SHOULD GRANT CERTIORARI TO DETERMINE WHETHER A GROUP EMPLOYEE WELFARE BENEFIT PLAN IS SUBJECT TO ERISA WHETHER OR NOT THE EMPLOYER HAS INDEFINITELY "GUARANTEED" THE CONTINUATION OF HEALTH INSURANCE BENEFITS.

A. Congress Intended That Employee Benefit Plans Be Governed Exclusively By A Uniform Body Of Federal Law.

In *Pilot Life* this Court observed that ERISA protects "participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and their beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to Federal courts." [4] The legal issues raised by the decision of the Nevada Supreme Court have national importance be-

[4] 481 U.S. at 44, *citing* 29 U.S.C. § 1001(b).

cause the effect of the decision is to deny ERISA protection to a large population of beneficiaries heretofore covered in Nevada, while similarly situated beneficiaries across the rest of the Nation remain covered.

Two years ago this Court announced in *Pilot Life* that ERISA comprehensively regulates employee benefit plans which, through the purchase of insurance or otherwise, provide medical, surgical or hospital care, or benefits in the event of sickness, accident, disability or death.[5] The pre-emption provisions of ERISA, the Court observed, are deliberately expansive and designed to establish plan regulation as exclusively a federal concern.[6] The Court placed significant reliance on the fact that the House and Senate sponsors emphasized both the breadth and importance of ERISA's pre-emption provisions.[7]

Congress' intent was to federalize the regulation of *all* employee benefit plans in order to eliminate the threat of conflicting or inconsistent regulation of such plans and create a uniform body of Federal law.[8] In *Pilot Life*,

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[5] 481 U.S. at 44.

[6] 481 U.S. at 46.

[7] *Id.* The Court noted the centrality of Representative Dent's description of the "reservation to Federal authority the sole power to regulate the field of employee benefit plans as ERISA's crowning achievement" and Senator Williams' explanation that the Act intended to pre-empt the field in order to eliminate the threat of conflicting or inconsistent State and local regulation of employee benefit plans, which principle was intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof which have the force or effect of law. *Id.*

[8] The underlying purpose of pre-emption is to eliminate the threat of conflicting and inconsistent state and local regulation. Federal pre-emption avoids this result by ensuring that the administration of an employee benefit plan will be governed by a single set of federal laws. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987).

the Court concluded that Congress made clear its intention that all suits brought by beneficiaries or participants under ERISA-regulated plans must be treated as federal questions governed by ERISA, and that Congress expected a federal common law of rights and obligations under ERISA plans would develop.[9]

Notwithstanding the Court's ruling in *Pilot Life*, the Nevada Supreme Court ruled that state law remedies were available to a beneficiary of an employee benefit plan claiming improper administration of insurance coverage—the exact claim this Court ruled in *Pilot Life* was pre-empted.[10] It did so by recognizing two novel limitations on the definition of an ERISA plan, and an ERISA plan participant. The ruling at issue, while favoring the beneficiary here, if allowed to stand will cause great harm and mischief to Nevada plan participants and beneficiaries. It also subjects *amicus* and other insurers offering group health insurance to employer-sponsored plans to conflicting standards: the same claim dispute in Nevada will be treated as governed by Nevada law, while in other States it will be subject to ERISA remedies and ERISA preemption. The Nevada opinion therefore raises important questions of federal law. No Court other than this one can resolve the inconsistent application of ERISA caused by the Nevada decision. Review by this Court is therefore urgently needed.

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[9] 481 U.S. at 56.

[10] In this case the Nevada Supreme Court reversed a trial court decision which, on the basis of ERISA's pre-emption of state law remedies for the mishandling of insurance claims, granted summary judgment against plaintiff (Cert. Pet. at 6a-7a). The Nevada Supreme Court remanded the case for plaintiff to proceed to trial on all her insurance bad faith causes of action (Cert. Pet. at 5a).

B. The Nevada Supreme Court Created A Novel Requirement That For A Plan To Be Governed By ERISA The Employer Must Guarantee The Continuation Of Employee Welfare Benefits. The Legitimacy Of This New Requirement Raises An Important Question Of Federal Law Requiring Review.

ERISA defines "employee welfare benefit plan" to mean (insofar as relevant here):

> any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer . . . to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment. . . .

ERISA § 3(1), 29 U.S.C. § 1002(1). Parsing the language of this statutory definition, federal courts of appeals have established a five element test to determine whether insurance benefits are subject to ERISA. To be an ERISA plan, there must be: (1) a plan, fund or program, (2) established or maintained, (3) by an employer or by an employee organization, or by both, (4) for the purpose of providing medical, surgical, hospital care, sickness, accident, disability, death, or other benefits not relevant here, (5) to participants or their beneficiaries. *Kanne v. Connecticut General Life Insurance Co.*, 859 F.2d 96, 98 (9th Cir. 1988); *Ed Miniat, Inc. v. Globe Life Insurance Group, Inc.*, 805 F.2d 732, 738 (7th Cir. 1986), *cert. denied*, 482 U.S. 915 (1987); *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982) (en banc). *Accord, Dodd v. John Hancock Mutual Life Insurance Co.*, 688 F. Supp. 564, 566-67 (E.D. Cal. 1988).

In recognition of the broad reach of ERISA coverage, the Department of Labor has promulgated regulations that narrowly define those few employee group health

benefit arrangements that are *not* "employee welfare benefit plans." With respect to plans funded by group insurance, the regulations exclude from ERISA coverage only those group insurance programs offered by an insurer to employees which meet each of the following criteria: (1) the employer makes no contributions; (2) participation in the program is completely voluntary for employees; (3) the sole functions of the employer with respect to the program are, without endorsing the program, to permit the insured to publicize the program to employees, to collect premiums through payroll deductions and to remit them to the insurer; and (4) the employer receives no consideration in connection with the program, other than reasonable compensation for administrative services actually rendered in connection with the payroll deductions. 29 C.F.R. § 2510.3-1(j) (1988). In these limited circumstances, an employer may be involved in a welfare plan without "establishing" or "maintaining" it. Until the decision in the instant case, most courts have held that a plan is included under ERISA coverage unless all four of these regulatory criteria are met. *See, e.g., Shiffler v. Equitable Life Assurance Soc.*, 663 F. Supp. 155, 160-61 (E.D. Pa. 1986), *aff'd*, 838 F.2d 78, 82 n.4 (3d Cir. 1988); *Kanne*, 859 F.2d at 99.

The welfare plan below did not meet all four of the requirements the DOL has set for non-ERISA plans. Indeed, the plan did not meet even one of these requirements.[11] The Nevada Supreme Court did not find to the

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[11] The record in this case, unquestioned by the Nevada Supreme Court, established that plaintiff was the owner of a business known as "The Bottle Stop" (Cert. Pet. at 1a-2a); that in 1974 "The Bottle Stop" subscribed to Beneficial Employees Security Trust's American Series Plan to procure health care benefits, including major medical benefits of up to $1,000,000 for herself and her full-time employees (Cert. Pet. at 3-4, 1a-2a); that the plan specified that partners or owners were considered "employees" for purposes of the plan if they worked 30 hours or more per week (Cert. Pet. at 3-4); that plaintiff, who managed the business and worked in it

contrary, but nevertheless determined that it was not an ERISA plan because it failed to meet a requirement created out of whole cloth by the court: that ERISA plans provide "some indication that an employer is committed to or has guaranteed the continuation of . . . benefits." Cert. Pet. at 4a.[12]

The legitimacy of this new requirement identified by the Nevada Supreme Court raises an important question of Federal law. If the court is correct, then many if not most plans now thought to be subject to ERISA are in fact *not* ERISA plans. Indeed, *no* welfare plans of which *amicus* is aware make any such guarantee of continuing benefits.

There is, to be sure, a commonly recognized "guarantee of continued benefits" requirement *elsewhere* in ERISA. Congress in enacting ERISA believed it was important that employers be required to guarantee the continuation of *pension* benefits—and so established detailed vesting requirements to ensure that employees' continued benefits be guaranteed.[13] The Nevada court has understood

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along with three other employees, had coverage and received her benefits under the plan through May, 1983, when it was terminated, and also received the one year extension of benefits provided thereafter (Cert. Pet. at 4-5, 2a).

[12] Apparently, The Bottle Stop's continuous maintenance of the program, annual filings on its behalf with DOL, and payment of premiums for period of over eight years (*see* Cert. Pet. at 3-4, 1a-2a) did not constitute such an indication of commitment to the court below.

[13] *See* ERISA § 203(a), 29 U.S.C. § 1053(a); 29 C.F.R. § 2530.203-1. Those standards effectively require the continuation of pension plans with respect to employees holding vested rights. However, Congress opted for less comprehensive vesting rules in order to strike a balance "between providing meaningful reform and keeping costs within reasonable limits." S. Rep. No. 383, 93d Cong., 2d Sess. 18, *reprinted in* 1974 U.S. Code Cong. & Admin. News 4890, 4904. Congress' election *not* to mandate any vesting or continuity requirements for welfare plans must be regarded as a conscious choice not to require a guarantee of continuation of such plans, unlike pension plans.

ERISA to impose the same requirements on *health and welfare* benefits—if they are to be considered "plans" subject to ERISA. This ruling could disqualify virtually every Nevada employee welfare plan [14] now reporting to the Secretary of Labor.[15] No other court has imposed such a requirement on health and welfare plans. Plainly, Congress intended no such requirement to be imposed on such plans. The Nevada court's opinion is so evidently incorrect that a summary reversal might well be appropriate. At the least, the Court should grant plenary review to address this important question of Federal law and ensure national uniformity in the application of ERISA.

C. The Nevada Supreme Court Has Determined That The Owner Of An Unincorporated Business Is Excluded From Coverage As An ERISA Plan Participant, Raising An Important Question Of Federal Law Requiring Review.

As an alternative rationale supporting its decision, the Nevada court ruled that plaintiff could not be considered an ERISA plan "participant" because she was the owner of an unincorporated business. This holding, too, is flatly inconsistent with the Department of Labor regulations governing plan participation. As a result of the court's ruling, many beneficiaries previously treated as protected by ERISA will *not* be covered by the statute in Nevada, while they are covered in all jurisdictions that apply the Department of Labor's regulations. Once again, this alternative holding raises important questions of Federal law that affect the day-to-day operations of a great many employee benefit plans.

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[14] Based upon a survey of trade associations and the Department of Labor by *amicus*, it is estimated that there are now five million employee welfare plans.

[15] *See* 29 C.F.R. §§ 2520.104a-1 to -7 (setting out the Labor Department's reporting and filing requirements).

While ERISA defines "participant" to be "any employee of an employer . . . eligible to receive benefits," 29 U.S.C. § 1002(7), it has long been the understanding of the Department of Labor and the insurance industry that ERISA covers individual proprietors and partners along with their employees, at least when the plan document includes the proprietors.[16] The Department of Labor regulations describe the self-employed as "participants," at least where, as in this case, the plan covers both the self-employed and common law employees.[17]

By failing to accept the DOL's treatment of the self-employed as beneficiaries, the Nevada court has placed insurers in an unfair and unnecessarily confused situation. For virtually all other purposes under ERISA, insurers and plans must treat the self-employed as participants protected by ERISA, entitled to all of the protections the law provides.[18] On the other hand, in Nevada at least, while the self-employed gain all of the benefits that come from ERISA, in suits against insurers they are entitled to bring state law claims and seek state law remedies not governed by ERISA's regulatory scheme and free from the pre-emption clauses of the Act. However Congress intended to treat the self-employed who are beneficiaries of group insurance along with their employees, it certainly did not intend this inconsistent treat-

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[16] *See* N.A.I.C. Group Health Insurance Definition and Group Health Insurance Standard Provisions Model Act, Section 1.

[17] 29 C.F.R. § 2510.3-3(b) (1987). While for some purposes the DOL defines "employee" more narrowly to exclude self-employed individuals, *see* 29 C.F.R. § 2510.3-3, the DOL has made clear in its regulations that this narrow definition of "employee" is to be used only to determine whether a "plan" exists, and is *not* to be used to determine whether a self-employed worker is a participant in a plan. *See* DOL Reporting and Disclosure Regulations, 40 Fed. Reg. 34525, 34528 (August 15, 1975). See also DOL Opinion Letters 79-8A and 81-54A.

[18] *See* cases cited at pages 15-16, *infra*.

ment that has resulted from the Nevada court's ruling. And only this Court is now in a position to remedy this inconsistent application of ERISA created by the Nevada opinion.

Where a plan is funded by the purchase of group insurance, ERISA's goal of uniform treatment of benefit claims is best served when self-employed individuals are also employee participants of the employee welfare benefit plan to which they subscribe. Once again we believe that the Nevada Supreme Court's opinion in this regard is so plainly wrong and so out of harmony with prevailing practice, that a summary reversal would be appropriate. In any event, this Court should at least grant plenary review to assure consistent application of the important federal principles adopted in ERISA.

II. THIS COURT SHOULD GRANT CERTIORARI TO RESOLVE A CONFLICT BETWEEN A STATE COURT OF LAST RESORT AND FOUR UNITED STATES COURTS OF APPEALS ON AN IMPORTANT QUESTION OF FEDERAL LAW.

A. The Nevada Supreme Court Created New Definitional Rules For ERISA Plans That Are Inconsistent With The Rules Applied By The Federal Courts.

The Nevada Supreme Court's disqualification of the plan under review from ERISA coverage creates a clear split between the highest court of a state and four United States Courts of Appeals. The Seventh, Ninth, Tenth and Eleventh Circuits have held that employer adoption of a group insurance plan for its employees creates an ERISA plan, so long as it meets the tests established by the Secretary of Labor. *See Kanne v. Connecticut General Life Insurance Co.*, 859 F.2d 96, 98 (9th Cir. 1988) (plan offered through a MET); *Ed Miniat, Inc. v. Globe Life Insurance Group, Inc.*, 805 F.2d 732, 738 (7th Cir. 1986), *cert. denied*, 482 U.S. 915 (1987); *Roe v. General American Life Insurance Co.*, 712 F.2d 450, 452 (10th Cir.

1983);[19] *Donovan v. Dillingham*, 688 F.2d 1367, 1371 (11th Cir. 1982) (en banc) (plan offered through a MET). *Accord*, *Dodd v. John Hancock Mutual Life Insurance Co.*, 688 F. Supp. 564, 566-67 (E.D. Cal. 1988); *Rizzi v. Blue Cross of Southern California*, 253 Cal. Rptr. 541, 543-47 (Cal. Ct. App. 1988). The Nevada decision, in stark contrast, imposes an additional requirement: that the employer guarantee the continuation of benefits. There is no doubt that the plan found *not* to be an ERISA plan by the Nevada court would be considered a plan by each of the courts of appeals to have considered this question.

In addition, the Nevada court's imposition of an additonal "guarantee of continuation" test not contained in the text of ERISA squarely conflicts with holdings by the Federal courts of appeals that the only criteria for finding a covered employee welfare benefit plan are those set out in the five-fold test of *Donovan v. Dillingham*.[20]

The Nevada court, moreover, is not the only court that has imposed additional, non-statutory criteria in order to avoid the pre-emptive effect of ERISA. In *Sayble v. Blue Cross of Southern California*, 255 Cal. Rptr. 144 (Cal. Ct. App. 1989), the California intermediate appellate court held that "the existence of an ERISA plan depends on the extent to which the employer is involved in the administration of the benefit program." *Id.* at 148.[21]

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[19] The *Roe* court explicitly recognized "some split of authority" on this issue. *See* 712 F.2d at 452 (employer sponsored disability program for which employees paid 100% of the disability premium).

[20] 688 F.2d 1367, 1371 (11th Cir. 1982) (en banc). *Accord*, *Kanne v. Connecticut General Life Insurance Co.*, 859 F.2d 96, 98 (9th Cir. 1988); *Ed Miniat, Inc. v. Globe Life Insurance Group, Inc.*, 805 F.2d 732, 738 (7th Cir. 1986), *cert. denied*, 482 U.S. 915 (1987). The five criteria are discussed at p. 7, *supra*.

[21] A petition for rehearing by the intermediate appellate court has been filed in *Sayble* and is now under consideration. The petition notes, among other things, the conflict between the *Sayble*

The court there expressed a concern that, if an employer's payment of premiums were sufficient to constitute a plan governed by ERISA, "every garden variety employee health insurance benefit would subject the paying employer, large or small, to ERISA's regulatory burdens, and would bind the insured employee to ERISA's remedies." *Id.* at 149. Similar concerns led the Fifth Circuit in *Taggart Corp. v. Life & Health Benefits Admin.*, 617 F.2d 1208 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030 (1981), to hold that an employee plan financed by insurance purchased through a MET was not an ERISA plan. This older pre-*Pilot Life* Fifth Circuit case, along with the Nevada Supreme Court, hold the view that Congress understood ERISA to be a limited federal enterprise covering only certain plans and certain workers. This Court and most other courts have reached the opposite conclusion.[22]

There is confusion in the courts on the alternative holding of the Nevada Supreme Court. The Seventh Circuit has held that an owner can be an employee and a plan participant under ERISA, *see Ed Miniat*, 805 F.2d at 740 n.14. The Third and Sixth Circuits in an analogous context have held that an employer may have dual status as a fiduciary under ERISA, *U.S. Steel Corp. v. Pennsylvania Human Relations Commission*, 669 F.2d 124, 126-28 (3d Cir. 1982); *Great Lakes Steel v. Deggendorf*,

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decision and that of another intermediate appellate court on indistinguishable facts in *Rizzi, supra.*

[22] There is already pending before the Court one petition for certiorari raising as a question presented the issue of the criteria necessary to establish an ERISA plan. *See Kanne v. Connecticut General Life Ins. Co.*, No. 88-1659, petition for cert. filed April 11, 1989. In the event the Court agrees with *amicus* that this issue should be given plenary consideration, the instant case is a better vehicle for that consideration than the pending petition in *Kanne*. The issue in *Kanne* apparently was not addressed by the trial court, and as a result the record appears to be deficient in relevant ways. Here, on the other hand, the issue was raised and addressed below.

716 F.2d 1101, 1104-05 (6th Cir. 1983). *See also Schwartz v. Gordon*, 761 F.2d 864, 869 (2d Cir. 1985) (Plans which cover both self-employed individuals and their employees governed by ERISA: "when the assets of employees and a self-employed employer are commingled, for example, the only way to assure the needed protection for the former is to protect the latter as well."); *Dodd*, 688 F. Supp. at 570; 29 C.F.R. § 2510.3-3(b).

On the other hand, the Nevada Supreme Court's alternate holding that a self-employed owner is *not* covered by ERISA finds support in a Tenth Circuit decision holding that individuals with dual status as employers and employees were ineligible for inclusion under ERISA, at least where the plan documents expressly excluded as eligible participants self-employed individuals, employers, and owners of contributing business organizations, *Peckham v. Board of Trustees*, 653 F.2d 424, 426-27 (10th Cir. 1981) (*Peckham I*).[23] Trial court decisions are in a similar state of confusion. *Compare Dodd v. John Hancock Mutual Life Insurance Co.*, 688 F. Supp. 564, 571-72 (E.D. Cal. 1988) (the owner of a corporation can be an "employee" and a participant under ERISA); *with Pitre v. Louisiana Health Service and Indemnity Co.*, 122 F.R.D. 497, 500 (W.D. La. 1988) (ERISA is inapplicable to the claim of a partner in a law firm). *See also, Peckham v. Board of Trustees*, 724 F.2d 100 (10th Cir. 1983) (*Peckham II*) (employers named in plan as participants *may* invoke ERISA jurisdiction to sue for restitution of contributions) (appeal following remand in 653 F.2d 424, *supra*); *Chase v. Trustees of Western Conference of Teamsters Pension Trust Fund*, 753 F.2d 744, 748-49 (9th Cir. 1985) (owning drivers of taxicabs should be considered "participants" for purpose of seeking restitution of plan contributions); *Giardono v. Jones*, 867 F.2d 409, 411-12 (7th Cir. 1989)

[23] Here, of course, the plan documents expressly named plaintiff Turnbow as an eligible participant. Cert. Pet. at 4.

(sole proprietor who only employed non-union employees and who therefore was only subscriber to union sponsored health care plan was not an ERISA "participant"); *Taggart*, 617 F.2d 1208 (no ERISA plan is established where a corporation simply buys insurance for its sole employee/owner). Review of the decision below is necessary to resolve the conflict and confusion evidenced by these disparate decisions.

B. The *Turnbow* Decision Creates The Very Patchwork Of Inconsistent State Regulation ERISA Was Enacted To Avoid.

The confusion among the state and Federal courts on these issues is undermining one of the primary goals Congress sought to accomplish in enacting ERISA. A major thrust of the program was to promote uniformity and eliminate the patchwork of inconsistent state and local regulation that plagued private employee benefit plans in the American economy, and retarded the development and the growth of private health insurance. "A virtually unanimous Congress enacted ERISA in order to encourage the establishment and growth of private" employer benefit plans. *Rettig v. Pension Benefit Guaranty Corp.*, 744 F.2d 133, 135 (D.C. Cir. 1984) (footnote omitted).[24]

ERISA's integrated federal scheme for employee benefits, along with its pre-emption of state law and remedies, serves to ensure uniformity in application of the Act's standards to employee welfare plans. Congress acted to promote the "uniformity of decision" necessary

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[24] *See also A-T-O, Inc. v. Pension Benefit Guaranty Corp.*, 634 F.2d 1013, 1021 (6th Cir. 1980); *Michigan United Food and Commercial Workers Unions v. Baerwaldt*, 572 F. Supp. 943, 949 (E.D. Mich. 1983), *rev'd on other grounds*, 767 F.2d 308 (6th Cir. 1985), *cert. denied*, 474 U.S. 1059 (1986) ("Implicit in the whole purpose of the Act is a desire to encourage private pension and welfare plans by promulgating uniform, reasonable, and non-oppressive federal requirements.")

for "administrators, fiduciaries and participants to predict the legality of proposed actions." S. Rep. No. 127, 93d Cong., 2d Sess. ——, *reprinted in* 1974 U.S. Code Cong. & Admin. News 4838, 4865.[25]

By permitting plan administrators, employers and beneficiaries reasonably to expect a measure of consistency in implementation of welfare plans among varied locations and in varied circumstances, the Act provides the predictability central to effective implementation of a private system of employee welfare.

The lesson of the *Turnbow* decision is that in Nevada an employee welfare plan, to qualify as an ERISA plan, must have an employer's "statement of intent to guarantee the continued furnishing of benefits" (Cert. Pet. at 4a), whereas plans in other states will remain subject to ERISA in the absence of such a requirement and participants and beneficiaries under the plans will continue to enjoy ERISA's protections. The Nevada court's decision is moreover an open invitation to employers to opt out of ERISA and its mandatory Federal requirements by announcing that they will not guarantee the continuity of benefits. As such, the decision is in considerable tension with the many court decisions that have held that Congress did not intend to allow employers offering benefit plans to "opt out" of ERISA coverage by failing to adhere to its filing and notice requirements.[26] Of

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[25] *E.g., Holland v. Burlington Industries*, 772 F.2d 1140, 1147 (4th Cir. 1985) (Congress' "major policy objective" was "*uniformity* in employee benefit laws") (emphasis in original), *aff'd mem. sub nom. Brooks v. Burlington Industries*, 477 U.S. 901 (1986); *Scott v. Gulf Oil Corp.*, 754 F.2d 1499, 1501 (9th Cir. 1985), *citing Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *see also* 120 Cong. Rec. 29,197 (1974) (statement by Rep. Dent); 120 Cong. Rec. 29,933 (1974) (statement by Sen. Williams).

[26] *See, e.g., Blau v. Del Monte*, 748 F.2d 1348, 1355 (9th Cir. 1984), as amended March 5, 1985, *cert. denied*, 474 U.S. 865 (1985); *Donovan v. Dillingham*, 688 F.2d at 1372.

course, only in Nevada may an employer "opt out" of ERISA. Similarly, in Nevada a self-employed operator of a business can never be an ERISA plan participant; if she crosses over to California [27] she is covered by ERISA. This is the very patchwork of regulation Congress sought to eliminate.

CONCLUSION

For the foregoing reasons, *amicus* urges this Court to grant the petition for certiorari.

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[27] *See Rizzi*, 253 Cal. Rptr. at 543-47.

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In the Supreme Court
OF THE
United States

OCTOBER TERM, 1988

PACIFIC MUTUAL LIFE INSURANCE COMPANY, *et al.*,
Petitioners,

v.

HARRIETTE TURNBOW,
Respondent.

MOTION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF AND BRIEF OF *AMICUS CURIAE* THE ASSOCIATION OF CALIFORNIA LIFE INSURANCE COMPANIES IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF NEVADA

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MOTION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF

The Association of California Life Insurance Companies ("ACLIC") respectfully requests leave to file the accompanying *amicus curiae* brief in support of Petitioner Pacific Mutual Life Insurance Company's ("Pacific Mutual") Petition for a Writ of Certiorari to the Nevada Supreme Court. Counsel for Pacific Mutual has consented in writing to ACLIC filing an *amicus curiae* brief; counsel for Respondent Harriett Turnbow has refused consent. ACLIC is a California nonprofit trade association whose members are domestic California life insurance companies and foreign life insurance companies which do business in California. One of the primary purposes of ACLIC is to represent the interests of its members, for their benefit and that of their policyholders, in substantial public policy matters which affect them.

At stake in this case is the goal of uniform regulation and certainty of remedies at the heart of the Employee

Retirement Income Security Act of 1974 ("ERISA"). The Court should resolve the disputes now raging among various Circuits and state courts as to what employee benefit plans come within the purview of ERISA. The determination of the issues raised by Pacific Mutual in the instant case will be of great importance to the people of the many states, including California, and therefore by definition of concern to ACLIC. Moreover, the California Appellate Courts have joined the fray with conflicting decisions in *Sayble v. Blue Cross of Southern California*, 207 Cal.App.3d 953 (1989), and *Rizzi v. Blue Cross of Southern California*, 206 Cal.App.3d 380 (1988). Thus, the issues in this case are of particular interest to ACLIC.

ACLIC has reason to believe that the issues it addresses concerning the need for uniform regulation under ERISA and the corresponding certainty of remedies will not be fully addressed by the parties. Indeed, Pacific Mutual's Petition does not discuss these issues in great depth. Moreover, the brief discussions of *Sayble, Rizzi* and the decision at issue here in ACLIC's brief will provide this Court with detailed information concerning the actions of California State Courts of Appeal which have decided an important question of federal law which has not been, but should be settled by this Court. This will aid the Court in determining whether to grant the Writ of Certiorari under the considerations in Rule 17.1(c) of the Rules of this Court.

For the foregoing reasons, ACLIC respectfully requests leave to file the accompanying *amicus curiae* brief.

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BRIEF OF *AMICUS CURIAE* THE ASSOCIATION OF CALIFORNIA LIFE INSURANCE COMPANIES IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF NEVADA

STATEMENT

The statement of this case is set forth in Pacific Mutual's Petition, which statement is adopted here.

ARGUMENT

This Court, having shut the front door and locked it, now finds the Nevada Supreme Court swinging the back door wide open. In *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41 (1987), this Court determined that state law claims and remedies concerning benefits under ERISA plans were preempted by the exclusive remedies specified in ERISA because Congress intended that Act to preempt

state regulation of employee benefit plans. The Nevada Supreme Court has now determined that the majority of America's employee health benefit plans — those where the employer simply purchases insurance and/or delegates administration to some other entity — are *not* covered by ERISA.

Suddenly, the *Pilot Life* decision is threatened with evisceration. Smaller and medium-sized "garden variety" employee benefit plans *are* subject to state law claims and remedies. The Nevada Supreme Court's rationale in *Turnbow* creates a gaping hole in ERISA, threatening its purpose and intent by limiting its scope to those plans collectively bargained for or otherwise required by some employer/employee contract.

This Court should grant Pacific Mutual's Petition for Writ of Certiorari because the Nevada Supreme Court's decision, as well as those of other courts, creates troublesome and unwarranted distinctions between ERISA plans and plans now ruled to be "non-ERISA plans." In turn, this problem seriously threatens the uniform set of federal regulations which encourages and enables many employers to provide benefits to their employees.

1. The Court Should Grant the Petition for a Writ of Certiorari to Protect Uniformity of ERISA Regulation

The Writ of Certiorari should be granted as varying state regulations will impair the providing of health benefits to employees. As *Turnbow* recognizes, by subscribing to the multiple-employer trust ("MET") underwritten by Pacific Mutual, small and medium-sized employers are able to obtain lower insurance rates. This benefit of METs is an accepted fact. *See Donovan v. Dillingham,* 688 F.2d 1367, 1370 (11th Cir. 1982) (the purpose of MET is to

allow small employers to secure group health coverage at more favorable rates); *Taggart Corp. v. Life & Health Benefit Admin.*, 617 F.2d 1208, 1210 (5th Cir. 1980) (MET allowed group insurance for employers too small to qualify for group rates). Reduced rates for group insurance — whether through a MET or otherwise — permit greater numbers of employers to provide their employees with health care benefits. Encouraging employers to provide such benefits to their employees is an obvious and essential goal of ERISA.

To encourage the growth and development of employee benefit plans, Congress desired a unified system of regulations of those plans to replace a patchwork of state and local rules and remedies. *See Fort Halifax Packing Co., Inc. v. Coyne*, ____ U.S. ____; 107 S.Ct. 2211, 2217 (1987). As explained in *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983), at page 105 n. 25, and reiterated in *Fort Halifax* at 107 S. Ct. 2217, an important goal of ERISA is to encourage efficient administration of employee benefit plans because inefficiencies in those plans caused by conflicting state regulations might result in a lowering of benefit levels, elimination of benefits or benefits not being provided in the first instance. The preemption provision of ERISA, found in 29 U.S.C. § 1144(a), is intended to ensure uniform regulation. Section 1144(a) contains language of "unparalleled breadth,"[1] and has a preemptive scope "as broad as its language." *Shaw, supra* at 99.

The Nevada Supreme Court has let in through the back door that which *Pilot Life* refused entry. *Turnbow* contains two holdings: first, that in order for a benefit plan to

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[1] *Holland v. Burlington Industries, Inc.*, 772 F.2d 1140, 1147 (4th Cir. 1985), *aff'd mem. sub. nom., Brooks v. Burlington Industries*, ____ U.S. ____; 106 S.Ct. 3267 (1986).

qualify as an ERISA plan, the employer must intend to continue providing guaranteed benefits on an ongoing basis; and second, that the *owner* of a business which maintains an ERISA plan is not considered to be an ERISA "participant," even though the owner's employees, who enjoy the same insurance coverage as the owner, are considered ERISA "participants."

The health care program involved in the present case provided group health benefits to respondent Harriette Turnbow and many others across the nation through the purchase of insurance from Pacific Mutual. The effect of the *Turnbow* decision is to subject Pacific Mutual, and similar ERISA claims fiduciaries, to the varying laws of the fifty states with respect to claims processing for those plans not deemed by the state courts to come within ERISA *and* the provisions of ERISA for those that are. Pacific Mutual faces the unenviable task of determining on each claim whether a particular employee benefit plan is or is not a plan for purposes of ERISA in order to determine the claims processing laws with which it must comply. Further, even if a particular employer is deemed to have created an ERISA plan, Pacific Mutual must then determine whether or not the individual claimant is or is not an *ERISA* participant so as to be subject to ERISA's exclusive claims processing regulations, fiduciary standards and civil enforcement remedies.

It is difficult to imagine a more nightmarish scenario. The inefficiencies created by 51 potential different sets of regulations could cause increased premiums, reductions in benefits or inability of employers to obtain needed insurance. Such a result cannot serve the purposes of ERISA and threatens the benefits of ERISA to participating American workers. This Court should grant the Petition for Writ of Certiorari in order to determine with

finality what the guidelines will be for determining whether a plan is one subject to ERISA. The need for uniformity is great, and the conflicting decisions in the Circuits and various states damaging.

2. The Nevada Supreme Court Has Created an Illogical Requirement That an Employer Must Intend to Guarantee the Continued Furnishing of Benefits in Order for ERISA to Apply

The gravamen of the Nevada Supreme Court's decision is that no employee welfare benefit plan can be within ERISA unless the employer *intends to guarantee* continued furnishing of benefits. Nowhere in 29 U.S.C. § 1002, the statute defining an ERISA plan, or in the governing regulations by the Department of Labor, can the requirement of intention "to guarantee the continued furnishing of the benefits" by an employer be found.

Turnbow fails to explain exactly how such intent on the part of an employer could be proven. Despite the facts of the instant case, the Nevada court concluded intent cannot be proven by the maintaining of insurance for employees for *nine* years. This test creates an impossible hurdle for an employee benefit plan to come within ERISA unless those plans are required by collective bargaining agreements or some other employee/employer contract.

The statistics cited in Pacific Mutual's Petition for a Writ of Certiorari reveal that over 145 million working Americans and their dependents are covered by employer or union-sponsored health benefit programs. Ninety-nine percent of employer health care plans involving fewer than 100 employees are insured, and 92% of the plans

involving 100 or more employees are insured.[2] Obviously, a tremendous number of health plan participants are potentially affected by ERISA. The overwhelming majority of those participants employed by small and medium-sized employers ultimately receive their benefit through insurance. Under the "intentions" test created by the Nevada Supreme Court, most of these individuals will not enjoy the protections of ERISA, nor will the ERISA fiduciaries involved enjoy the certainty and uniformity of ERISA regulation and remedies.

3. The Petition for a Writ of Certiorari Should be Granted as There is a Significant Split in Authority and Those Cases Favoring Non-ERISA Coverage are Incorrect

Pacific Mutual's Petition for a Writ of Certiorari details the conflicts between various Circuit courts and among the state courts. What can be gleaned from Pacific Mutual's discussion is that many courts have considered the purchase of insurance by an employer as substantial evidence of an ERISA plan[3] and sometimes treated it as sufficient in and of itself.[4] Other courts, such as the Nevada Supreme Court, have created varying exceptions to these rules.

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[2]Petition for a Writ of Certiorari to the Supreme Court of Nevada, page 27, n. 35.

[3]*Kanne v. Connecticut General Life Ins. Co.*, 859 F.2d 96, 99 (9th Cir. 1988); *Credit Managers Ass'n v. Kennesaw Life and Acc. Ins. Co.*, 809 F.2d 617, 625 (9th Cir. 1987). *Donovan, supra* at 1373.

[4]*See Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277, 280 (11th Cir. 1987); *Eversole v. Metropolitan Life Ins. Co., Inc.*, 500 F.Supp. 1162, 1165 (C.D. Cal. 1980).

Of particular importance to ACLIC are the California state court cases of *Sayble v. Blue Cross of Southern California*, 207 Cal.App.3d 953 (1989), and *Rizzi v. Blue Cross of Southern California*, 206 Cal.App.3d 380 (1988). The different results in these cases further demonstrate the need for this Court to grant Pacific Mutual's Petition.

Rizzi reviewed the various regulations promulgated by the Department of Labor as well as its opinion letters and concluded that when an employer purchased insurance and, by the terms of the insurance arrangement, was involved in certain initial administrative details,[5] ERISA preempted state common law and statutory remedies for alleged mishandling of claims. *Sayble*, on the other hand, in an aggressive and unwarranted attack upon ERISA, ruled that an employer must do much more than merely fund premiums payments for group insurance.

Without specifying what administrative activity the employer must engage in, the *Sayble* court concluded that because "there was no employer-operated plan, there was no potential for employer abuses such as self dealing, imprudent investing, and misappropriation of plan funds" the rationale of ERISA would not be served. *Sayble, supra* at 962. The *Sayble* decision, which effectively removes all non-employer administered benefit plans from ERISA, is supposedly predicated upon this Court's decision in *Fort Halifax*.

Fort Halifax involved the issue of whether a *one-time* severance pay mandated by state law was preempted by ERISA. The Court concluded that this single payment

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[5]The only administrative activities other than paying premiums specified in *Rizzi* are advising which employees were to be enrolled in the plan and which should be terminated, and being deemed as the party to whom notice of changes was sufficient. *Rizzi, supra* at 390-91.

was not within ERISA because there was no ongoing plan:

> "The requirement of a one-time lump-sum payment triggered by a single event requires no administrative scheme whatsoever to meet the employer's obligation. The employer assumes no responsibility to pay benefits on a regular basis, and thus faces no periodic demands on its assets that create a need for financial coordination and control. Rather, the employer's obligation is predicated on the occurrence of a single contingency that may never materialize." *Fort Halifax, supra,* 107 S.Ct. at 2218.

Fort Halifax raises an important concern for applying a "purposes of ERISA" test, but its facts do not support *Sayble's* conclusions. An employer paying insurance premiums for group coverage on behalf of its employees *does* face "periodic demands on its assets that create a need for financial coordination and control." Moreover, employers who purchase group insurance must select the participants, handle enrollment, pay the premiums and, therefore, maintain financial integrity.

Also overlooked by *Sayble* and *Turnbow*, the delegation of administrative activity to an insurer through the payment of premiums constitutes an ongoing plan which does involve tremendous administrative activity. By definition, the investigation, consideration and payment or denial of submitted claims is administrative in nature. The mere fact that, as in over 90% of *all* employee benefit plans,[6] the employer delegates these obligations to a third party as expressly permitted by ERISA rather than doing them

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[6]Petition for a Writ of Certiorari to the Supreme Court of Nevada, page 27, n. 36.

itself should not determine whether an ERISA plan has been established.

4. Turnbow Should be Considered a Participant of an ERISA Plan

The Supreme Court of Nevada also concluded that even if an ERISA plan was created, Turnbow was not a participant thereunder. Turnbow was the owner of a business that employed three other people. In fact, it makes no sense to differentiate between the owner of an enterprise and her three employees, with respect to who qualifies as a "participant" under an ERISA plan.

Turnbow would have an enormously disruptive effect on the operations of employee benefit plans and their claims fiduciaries. If the Nevada Supreme Court is correct in this regard, then claims fiduciaries under ERISA will face 51 potential differing sets of regulations not merely for varying plans, but also for individual participants within those plans. The claims fiduciary will be required to attempt the difficult task of determining whether a participant has a substantial equity interest in the business in which he or she is engaged, so as to be considered an employer under the applicable state's laws. Under this ruling, the nightmare merely worsens.

The goal of uniformity of federal regulation cannot be served by the uncertainty created when a participant's employment status determines what law will govern a claim and the handling thereof. As argued above, varying regulations create inefficiencies which ERISA seeks to avoid. The Nevada Supreme Court should not be allowed to create a quagmire of regulations which could place health insurance beyond the reach of small or medium-sized employers or reduce or eliminate those benefits which are now provided.

5. Conclusion

For the foregoing reasons, *Amicus Curiae* The Association of California Life Insurance Companies urges this Court to issue a Writ of Certiorari to review the judgment and opinion of the Nevada Supreme Court.

Dated: April 19, 1989

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STATE OF CALIFORNIA
COUNTY OF LOS ANGELES } ss.:

I am a citizen of the United States and a resident of or employed in the City of Los Angeles, County of Los Angeles; I am over the age of 18 years and not a party to the within action; my business address is 1706 Maple Avenue, Los Angeles, California 90015.

On April 21, 1989, I served three copies of the within Motion for Leave to File *Amicus Curiae* Brief and Brief of *Amicus Curiae* in re: "Pacific Mutual Life Insurance Company, et al., vs. Harriette Turnbow" in the Supreme Court of the United States, No. 88-1546, on all parties interested in said action, by placing three true copies thereof enclosed in a sealed envelope, with postage thereon fully prepaid, in the United States Post Office mail box at Los Angeles, California, addressed as follows:

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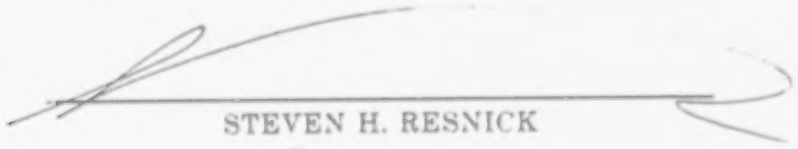
All Parties required to be served have been served.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on April 21, 1989, at Los Angeles, California.



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MOTION FILED
MAY 16 1989

(5)

No. 88-1546

IN THE
Supreme Court of the United States
OCTOBER TERM, 1988

PACIFIC MUTUAL LIFE INSURANCE COMPANY, *et al.*,
Petitioners,
v.
HARRIETTE TURNBOW,
Respondent.

MOTION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF AND BRIEF OF THE MERCHANTS AND MANUFACTURERS ASSOCIATION IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF NEVADA

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

No. 88-1546

PACIFIC MUTUAL LIFE INSURANCE COMPANY, *et al.*,

Petitioners,

v.

HARRIETTE TURNBOW,

Respondent.

MOTION FOR LEAVE TO FILE *AMICUS CURIAE* BRIEF

The Merchants and Manufacturers Association (the "Association") respectfully requests leave to file the accompanying *amicus curiae* brief in support of Petitioner Pacific Mutual Life Insurance Company's ("Pacific Mutual") petition for a *writ of certiorari* to the Nevada Supreme Court. Counsel for Pacific Mutual has consented in writing to the Association filing an *amicus curiae* brief; counsel for Respondent Harriette Turnbow has refused consent.

The Association is a California non-profit corporation. Its purpose is to assist its member firms in the management of their human resources. More than 3,700 employers of varying sizes and from various industries are members of the Association. The members collectively employ over 1,000,000 employees in the State of California and also conduct business operations in other

states, including the State of Nevada. The Association respectfully submits that its collective experience in employment matters, including its appearance as *amicus curiae* in state and federal forums over a period of many decades, gives it a unique ability to focus on the short and long term impact and implications of the legal issues under consideration in this case.

The decision of the Nevada Supreme Court in this case adds to the list of those federal and state courts presently split over the critical issue of what constitutes an "employee welfare benefit plan" under the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 832, 29 U.S.C. §§ 1001-1461 (1982 & Supp. V 1987) ("ERISA"). This issue lies at the core of ERISA's regulation and its preemption of state law regarding employer-provided health, medical and other "welfare" benefits. Unless corrected by this Court, the decision of the Nevada Supreme Court will engender further confusion among the courts and employers and will create significant burdens for employers that Congress did not intend to impose. Inevitably, these factors will lead to a decline in the willingness and ability of employers to provide such benefits, a result directly contrary to the intent of Congress in enacting ERISA. In addition to the need to preserve ERISA's nationwide uniformity of regulation over employee benefit plans, the questions presented by the petition in this case are particularly important to the Association since the California state courts have themselves reached inconsistent views as to what constitutes an employee welfare benefit plan. Unlike the petitioner and the other *amici* who have thus far sought leave to file briefs, all of which represent the views of insurance companies, the Association's interest lies in explaining the views of its member employers on these issues of significant importance to their businesses and their employees.

For the foregoing reasons, the Association respectfully requests leave to file the accompanying *amicus curiae* brief.

Respectfully submitted,

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1988

No. 88-1546

PACIFIC MUTUAL LIFE INSURANCE COMPANY, *et al.*,
Petitioners,

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HARRIETTE TURNBOW,
Respondent.

BRIEF OF *AMICUS CURIAE* THE MERCHANTS AND MANUFACTURERS ASSOCIATION IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI TO THE SUPREME COURT OF NEVADA

STATEMENT

The statement of this case is set forth in Pacific Mutual's petition, which statement is adopted here.

ARGUMENT

The Court should grant the petition for a *writ of certiorari* because the decision of the Supreme Court of Nevada creates an incorrect and unworkable standard for determining the existence of an employee welfare benefit plan subject to the Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 832, 29 U.S.C. §§ 1001-1461 (1982 & Supp. V 1987) ("ERISA"). In so doing, it negates the uniform federal regulation of such plans which Congress intended and which this Court has repeatedly recognized through its decisions. Moreover, the decision deepens a split of au-

thority among federal and state courts which can only be resolved by this Court. The Court should also review the additional holding of the Nevada Supreme Court that a sole proprietor cannot be a "participant" in an ERISA plan since that conclusion, contrary to Congressional intent, would subject ERISA plans to simultaneous state and federal regulation.

I. THIS COURT SHOULD GRANT REVIEW REGARDING THE STANDARD FOR DETERMINING WHEN AN EMPLOYER HAS ESTABLISHED AN EMPLOYEE WELFARE BENEFIT PLAN.

A. The Decision Of The Nevada Supreme Court Is Inconsistent With ERISA's Language, Agency Interpretation, And Congressional Intent.

The principal question presented by the petition is one of importance to all private sector employers and their employees. As this Court has noted, in enacting ERISA and its sweeping preemption provision, Section 514(a), 29 U.S.C. § 1144(a) (1982), Congress made an express decision "to afford employers the advantages of a uniform set of administrative procedures governed by a single set of regulations," *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987), and to "'eliminat[e] the threat of conflicting or inconsistent State and local regulation of employee benefit plans.'" *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987) (quoting 120 Cong. Rec. 29933 (1974)). The decision of the Nevada Supreme Court reverses that Congressional intent and would leave the large majority of employee welfare benefit plans, including many of those sponsored by the Association's members for their employees, unregulated by ERISA and subject solely to state law.

As a matter of statutory interpretation, the Nevada Supreme Court's decision is plainly incorrect. Under Section 4(b) of ERISA, 29 U.S.C. § 1003(b) (1982), the coverage of the statute extends, with exceptions not relevant here, to "any employee benefit plan" which is de-

fined in Section 3(3), 29 U.S.C. § 1002(3) (1982), to include an "employee welfare benefit plan." ERISA Section 3(1), 29 U.S.C. § 1002(1) (1982), provides that the term "employee welfare benefit plan" shall include "any plan, fund or program . . . established or maintained by an employer . . . for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, . . . medical, surgical, or hospital care or benefits . . . ." There is no dispute that the major medical benefits at issue here are the type of benefits specified for coverage under an ERISA-covered employee welfare benefit plan. It is also undisputed that these benefits were provided as a result of an employer's subscription to a "trust created to pool small employers together to permit them to obtain lower insurance rates," Petition for *Writ of Certiorari* (Mar. 20, 1989) ("Cert. Pet.") at 2a, and that such benefits were provided for the sole proprietor, who owned the employer, and for three employees through the employer's payment of premiums over eight and one-half years. *Id.* Under a plain reading of the statutory language and its interpretation by most federal circuits, proof of these elements should be more than sufficient to establish that this benefit program is an ERISA-covered plan. The Nevada Supreme Court, however, inserted a new requirement into ERISA's statutory language, by holding that an ERISA plan exists only where "there is some indication that an employer is committed to or has guaranteed the continuation of such benefits" and that no ERISA plan exists "where, as here, there is no indication that the employer intended to guarantee the continued furnishing of the benefits." *Id.* at 4a. That requirement cannot be justified by the statutory language, and, for that reason alone, the decision is in error.

In addition to rewriting the statutory language, the decision also ignores the views consistently expressed by the Department of Labor, the federal agency primarily responsible for administration and enforcement of ERISA,

as to employee welfare benefit plans. In a regulation promulgated in 1975, early in the administration of ERISA, the Department of Labor excluded from coverage as an "employee welfare benefit plan" a "group or group-type insurance program offered by an insurer to employees" if the program met four criteria designed to determine whether the program was established or maintained by an employer.[1] 29 C.F.R. § 2510.3-1(j) (1988). Although the regulation expressly defines only arrangements which are excluded from ERISA coverage, the Department of Labor has consistently interpreted the term "employee welfare benefit plan" as including an arrangement under which an employer purchases welfare benefits for its employees either directly or through subscription to a trust, unless all of the criteria in the regulation for exclusion from ERISA coverage are present.[2]

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[1] Under the regulation, a program is excluded from ERISA coverage if: (1) the employer makes no contributions, (2) participation is completely voluntary for employees, (3) the employer does not endorse the program but permits the insurer to publicize the program and collects and remits to the insurers premiums paid by employees and (4) the employer receives no consideration except compensation for actual administrative services. 29 C.F.R. § 2510.3-1(j) (1)-(4) (1988).

[2] In *Taggart Corp. v. Life & Health Benefits Admin., Inc.*, 617 F.2d 1208 (5th Cir. 1980), the Secretary of Labor submitted an *amicus curiae* brief urging the court to declare that an employer's subscription to a multiple employer trust ("MET") "'established a single employer welfare plan.'" *Id.* at 1211 (quoting Brief for Secretary of Labor as *amicus curiae* at 15). Subsequently, in *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982), a case brought by the Secretary of Labor, the court accepted the position advanced by the Secretary that employers which had subscribed to a MET, had established "employee welfare benefit plans" subject to ERISA. *Id.* at 1375.

Similarly, the Department of Labor has consistently taken the position in interpretive letters that where unrelated employers subscribe to a MET to provide welfare benefit coverage for their employees, while the MET itself may not be an employee welfare benefit plan, each subscribing employer will have established its own separate employee welfare benefit plan under Title I of ERISA. *See,*

Only recently, in *Massachusetts v. Morash*, 57 U.S.L.W. 4429 (U.S. Apr. 18, 1989), this Court relied on a different section of this same regulation and on a subsequent Department of Labor interpretation, in holding that certain vacation pay practices did not constitute "employee welfare benefit plans." *Id.* at 4432 & n.14.

The Nevada trial court in this action properly applied this regulation and found that the benefits program at issue failed at least three of the regulation's four criteria for exclusion from ERISA coverage, because the employer had endorsed the benefits program, had automatically enrolled its employees for coverage, and had paid all of the applicable premiums. Cert. Pet. at 7a. Thus, the employer's benefit program was not excluded from coverage under the Department of Labor regulation and was an employee welfare benefit plan, as that term has been consistently interpreted by the Department. Neither the regulation nor any subsequent agency interpretation, however, was mentioned or addressed in the decision of the Nevada Supreme Court.

The Nevada Supreme Court's requirement that an ERISA-covered welfare plan must contain an employer commitment or guarantee of "the continued furnishing of the benefits" also imposes on employers a feature which Congress itself did not provide and manifestly did not intend. Cert. Pet. at 4a. Employee benefit plans covered by ERISA can be classified as either or both "employee pension benefit plan[s]" or "employee welfare benefit plan[s]," ERISA Section 3(3), 29 U.S.C. § 1002 (3) (1982). As to pension plans, ERISA does impose a

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e.g., United States Department of Labor, ERISA Opinion Letters 87-11A (Dec. 21, 1987), 87-02A (Jan. 8, 1987), 86-08A (Feb. 3, 1986), 82-59A (Nov. 11, 1982), 81-84A (Dec. 9, 1981), 81-73A (Sept. 24, 1981), 80-10A (Feb. 11, 1980) and 79-54A (Aug. 3, 1979). The administrative interpretation of ERISA by the Department of Labor which Congress entrusted with the statute's enforcement is entitled to great deference. *Massachusetts v. Morash*, 57 U.S.L.W. 4429, 4431 (U.S. Apr. 18, 1989).

variety of requirements designed to enforce an employer's commitment to provide promised benefits. Chief among these are Section 203(a) of ERISA, 29 U.S.C. § 1053(a) (1982 & Supp. V 1987), which requires each ERISA-covered pension plan to meet minimum standards for vesting of benefits, and Section 204(a), 29 U.S.C. § 1054(a) (1982 & Supp. V 1987), which requires that pension benefits be accrued in annual increments. Defined benefit pension plans are also required to provide for advance funding of benefits under part 3 of Title I of ERISA, 29 U.S.C. §§ 1081-86 (1982 & Supp. V 1987), and employer liability for, and certain federal guarantees of, such benefits are provided in Title IV of ERISA. 29 U.S.C. §§ 1301-1461 (1982 & Supp. V 1987). Even these requirements, however, have never been interpreted to require, least of all as a matter relevant to coverage under the statute, the type of open-ended employer commitment to continued provision of benefits envisioned by the Nevada Supreme Court.[3] Moreover, welfare plans, which

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[3] The Internal Revenue Service does require, as a condition of qualification as a plan entitled to favorable treatment under 26 U.S.C. § 401(a) (1982 & Supp. V 1987), that a pension plan be intended to be maintained permanently. Treas. Reg. 26 C.F.R. § 1.401-1(b)(2) (1988). Moreover, Section 89(k)(1)(E), 26 U.S.C. § 89(k)(1)(E) (Supp. V 1987) was added to the Internal Revenue Code for plan years beginning in 1989 to require, as a condition of tax qualification, that welfare benefit plans be established with the intention of being "maintained for an indefinite period of time." Obviously, Congress believed that this was a new requirement, the addition of which required amendment of the Code. Under a proposed Internal Revenue Service regulation, a plan will be treated as established with the intent that it will be maintained indefinitely if it is established and maintained for at least a consecutive twelve month period. Prop. Treas. Reg. § 1.89(k)-1, 54 Fed. Reg. 9460, 9496 (1989). More significantly, however, these requirements affect only such plans' entitlement to favorable tax treatment under the Internal Revenue Code and not their coverage as employee benefit plans under Title I of ERISA. *Cf. Donovan v. Shaw*, 668 F.2d 985, 990-91 (8th Cir. 1982) (Title I of ERISA applies to all covered employee benefit plans regardless of their tax-qualified status).

are much less extensively regulated by the statute, *see Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985), are expressly excluded from these requirements. *See* ERISA §§ 201(1), 301(a)(1), 4021(a)(1), 29 U.S.C. §§ 1051(1), 1081(a)(1), 1321(a)(1) (1982). The circuit courts have, thus, uniformly held that benefits under a welfare plan do not automatically vest and may be eliminated freely by the employer. *Moore v. Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988) (employer may reserve its right to amend or terminate medical benefit plans); *Young v. Standard Oil (Indiana)* 849 F.2d 1039, 1045 (7th Cir.) (an employer may unilaterally amend or eliminate a severance benefit plan which is an employee welfare benefit plan), *cert. denied*, 109 S. Ct. 529 (1988); *In re White Farm Equip. Co.*, 788 F.2d 1186, 1193 (6th Cir. 1986) ("we discern no basis for finding mandatory vesting in ERISA for retiree welfare benefits"). The Nevada Supreme Court decision ignores these decisions and undoes the intent of Congress by imposing substantive requirements on employee welfare benefit plans under the guise of interpreting ERISA's coverage. For that reason also, the decision is in error and should be reversed by this Court.

B. The Nevada Supreme Court Decision Adds To A Conflict Among Federal And State Court Decisions.

The Nevada Supreme Court's decision rests on that court's adoption of a standard for ERISA coverage articulated by the Court of Appeals for the Fifth Circuit in *Taggart Corp. v. Life & Health Benefits Admin., Inc.*, 617 F.2d 1208 (5th Cir. 1980) ("*Taggart*"), *cert. denied*, 450 U.S. 1030 (1981). The decision also mentions, but mischaracterizes, the decision of the Court of Appeals for the Eleventh Circuit in *Donovan v. Dillingham*, 688 F.2d 1367 (11th Cir. 1982) ("*Dillingham*") in which the *en banc* court disagreed with the broad rationale of *Taggart* and declined to adopt it as binding within the Eleventh Circuit. Both *Taggart* and *Dillingham* involved, as does this case, employers that provided welfare bene-

fits to employees through subscriptions to a multiple employer trust ("MET"). Holding that the employer had not created an ERISA plan through that subscription, the *Taggart* court stated, in a passage quoted with approval by the Nevada Supreme Court: "[W]e cannot believe that [ERISA] regulates bare purchases of health coverage where, as here, the purchasing employer neither directly nor indirectly owns, controls, administers, or assumes responsibility for the policy or its benefits." *Taggart*, 617 F.2d at 1211 (*quoted in* Cert. Pet. at 3a). In *Dillingham*, the Court agreed with the holding of *Taggart* on its particular facts, but stated that "[i]f *Taggart* implies that an employer or employee organization that only purchases a group health insurance policy or subscribes to a MET to provide health insurance to its employees or members cannot be said to have established or maintained an employee welfare benefit plan, we disagree." *Dillingham*, 688 F.2d at 1375. Thus, *Dillingham* created, in rationale if not result, a "split of authority" in the federal circuits. *Roe v. General American Life Ins. Co.*, 712 F.2d 450, 452 (10th Cir. 1983). As described in greater detail in Pacific Mutual's petition, subsequent federal decisions have generally adhered to the *Dillingham* line of analysis,[4] but certain state court decisions, including the decision in this case, continue to give vitality to *Taggart*. Cert. Pet. at 16-20.[5] Moreover, *Taggart* has never been overruled in the Fifth Circuit, and its rationale was recently cited by a district court in that

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[4] *See Kanne v. Connecticut Gen. Life Ins. Co.*, 859 F.2d 96, 98-99 (9th Cir. 1988); *Ed Miniat, Inc. v. Globe Life Ins. Group, Inc.*, 805 F.2d 732, 738 (7th Cir. 1986), *cert. denied*, 482 U.S. 915 (1987); *Roe v. General American Life Ins. Co.*, 712 F.2d at 452; *see also Rizzi v. Blue Cross of Southern Cal.*, 206 Cal. App. 3d 380, 253 Cal. Rptr. 541 (1988).

[5] Of particular concern to the Association and its California membership is the decision in *Sayble v. Blue Cross of Southern Cal.*, 207 Cal. App. 3d 953, 255 Cal. Rptr. 144 (1989) (holding that an employer's purchase of group health insurance is insufficient to establish an ERISA plan).

circuit. *Pitre v. Louisiana Health Serv. & Indemnity Co.*, 122 F.R.D. 497, 499 (W.D. La. 1988). Thus, in addition to the conflict between the decision of the Nevada Supreme Court in this case and those circuit court decisions which have endorsed *Dillingham*, the continuing conflict presented by *Dillingham* and *Taggart* merits resolution by this Court.

C. The Decision Of The Nevada Supreme Court Presents A Nationwide Issue Of Great Importance To Employers.

The practical adverse consequences of the *Turnbow* decision on employers are several. Many of the Association's members are interstate employers with offices in other states, including a significant presence in Nevada. Due to the current conflict of case authority, employers which provide benefits to employees in different states, even in states within the same federal circuit, can only guess in many cases whether their health and medical benefit programs will be covered under federal or state law. Where Congress envisioned national uniformity of federal regulation and the complete displacement of state regulation, *see Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9 (1987) and *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99 n.20 (1983), employers presently face only uncertainty and inconsistency of regulation. This alone will deter employers from establishing or maintaining employee benefit plans.

In those jurisdictions, including Nevada and California, where employers run the risk that their health and medical benefit programs will be judged under the *Turnbow* standard, they have several significant reasons to consider not providing those benefits or discontinuing those benefits that they already provide. The decision of the Nevada Supreme Court articulates a completely amorphous and unworkable standard for determining when an employer would be deemed to have sufficiently "guaranteed" or "committed to" a benefits program in order

for ERISA coverage to attach. Cert. Pet. at 4a. The Nevada Supreme Court held that an employer which enrolled its employees for benefits coverage, and maintained that coverage continuously for eight and one-half years by paying all of the applicable premiums, had not demonstrated a sufficient commitment to provision of those benefits for ERISA to apply. *Id.* Faced with such a standard, employers that are considering whether to provide such coverage for the first time will have no idea when, if ever, they will be considered to have established ERISA plans and whether, if business fortunes make continued provision of the benefits impossible, they will be judged in hindsight to have lacked sufficient commitment to provision of the benefits so that ERISA coverage will not exist. Thus, the test established by the Nevada Supreme Court would be certain to discourage employers from establishing benefit programs in the first instance. Moreover, if the *Turnbow* decision means that employers must formally "commit to" or "guarantee" that they will continue to furnish the benefits which have been initially provided, the financial disincentives to providing such benefits in the first instance will be enormous. Particularly given the recent trends in escalation of health care costs, employers would fear being locked into benefits programs which they ultimately could not afford. Inevitably, the result would be that employers would decline to provide such benefits or would provide them only at minimal levels below those considered otherwise acceptable by employees.

Although the Nevada Supreme Court dismissed the benefits program at issue as "the bare purchase[] of health insurance," *id.*, for most employers the purchase of insurance to provide such benefits is not merely one option, it is the only option, since only the largest employers could run the risk of providing such benefits from their own assets. It is, of course, possible for an employer to purchase insurance and still administer the claims for its

own employees. Most employers, however, are not equipped to perform, and do not want the burden and expense of performing, this function. Thus, it is extremely common for insurance carriers also to administer claims for the benefits they insure. *See e.g., Credit Managers Ass'n v. Kennesaw Life & Accident Ins.*, 809 F.2d 617, 626 (9th Cir. 1987); *Eversole v. Metropolitan Life Ins. Co.*, 500 F. Supp. 1162, 1165 (C.D. Cal. 1980); *see also* 29 C.F.R. § 2560-503-1(g)(2) (1988). If the *Turnbow* standard means that there is no ERISA coverage where an employer purchases insurance to provide benefits, or at least where the employer does not itself administer the benefits, then most employers which currently provide health and medical benefits would be subject to state law rather than ERISA.[6]

For these reasons, ERISA's purpose of expanding employee benefit coverage through uniform federal regulation would be subverted if the *Turnbow* decision is not reversed by this Court. Thus, the question presented here is of great importance for employers and employees throughout the nation, and review by this Court is both necessary and appropriate.

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[6] This would create the very "patchwork scheme of regulation" which, as this Court has noted, "might lead those employers with existing plans to reduce benefits, and those without such plans to refrain from adopting them." *Fort Halifax Packing Co. v. Coyne*, 482 U.S. at 11. Moreover, because state law would provide damage remedies that are not provided by ERISA, the cost of the available insurance would inevitably increase, either causing insurers to leave the market or, more likely, making such insurance too expensive for small employers. In *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134 (1985), this Court held that damage remedies were not available in suits for breach of fiduciary duty under ERISA. Although the Court reserved the question whether such damage remedies were available in suits regarding benefits under an ERISA plan, the circuit courts have uniformly ruled against the availability of such damage remedies. *See Sokol v. Bernstein*, 803 F.2d 532, 534 (9th Cir. 1986); *Sommers Drug Stores Co. Employee Profit Sharing Trust v. Corrigan Enters.*, 793 F.2d 1456, 1462-65 (5th Cir. 1986), *cert. denied*, 479 U.S. 1034 (1987); *Varhola v. Doe*, 820 F.2d 809, 817 (6th Cir. 1987).

II. THE COURT SHOULD ALSO GRANT REVIEW TO DETERMINE WHETHER A SOLE PROPRIETOR CAN BE COVERED UNDER AN ERISA PLAN.

The second question presented by the petition, while less developed in the case law, is also a question of nationwide importance to employers and the employee benefit plans they sponsor. As a separate ground for its decision, the Nevada Supreme Court held that, even if an ERISA plan did exist in this case, the plaintiff, who was the sole proprietor of the company which created that plan, was not an employee of that company and could not be a participant or beneficiary of the plan. Thus, reasoned the court, because the plaintiff had no ERISA-based remedies, her state law causes of action could not be preempted by ERISA. This holding is also in error and wildly inconsistent with ERISA's goal of uniform federal regulation. The practical significance of this holding is that an employer which is an unincorporated sole proprietorship or partnership may sponsor a single program of health benefits, one part of which is subject to ERISA, while the remainder is subject to state law.

As set forth in greater detail in Pacific Mutual's petition, Cert. Pet. at 21-26, this aspect of the Nevada Supreme Court's decision is also inconsistent both with applicable Department of Labor regulations and with the weight of authority among the circuit courts. More importantly, it creates the very overlap and conflict between federal and state regulation, within a single plan or program of benefits, which ERISA expressly sought to eliminate by preempting state law. ERISA's preemption provision must be construed to avoid "[t]he administrative impracticality of permitting mutually exclusive pockets of federal and state jurisdiction within a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. at 107-08. Otherwise, as

this Court warned in *Fort Halifax Packing Co. v. Coyne*, "[f]aced with the difficulty or impossibility of structuring administrative practices according to a set of uniform guidelines, an employer may decide to reduce benefits or simply not to pay them at all." 482 U.S. at 13 (footnote omitted).

CONCLUSION

For the foregoing reasons, the Association, as *amicus curiae*, urges this Court to grant the petition for a *writ of certiorari*.

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No. 88-1546

IN THE
Supreme Court of the United States
OCTOBER TERM, 1988

PACIFIC MUTUAL LIFE INSURANCE COMPANY, *et al.*,
Petitioners,

v.

HARRIETTE TURNBOW,
Respondent.

On Petition for a Writ of Certiorari to the Supreme Court of Nevada

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REPLY BRIEF FOR PETITIONERS

As the Petition demonstrates, the Nevada Supreme Court's decision, by labeling a garden variety insured health care plan "non-ERISA governed," deliberately undermines Congress' clearly expressed intent to impose uniform federal regulation over *all* employer-sponsored health care plans, self-funded and insured alike. ERISA section 3(1), 29 U.S.C. § 1002(1). This parochial decision, which engenders further conflict and confusion in the lower courts on this critical ERISA coverage and preemption issue, intentionally serves to nullify ERISA

and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), for the overwhelming majority of American health care plans. In addition, by excluding the working self-employed from ERISA's civil enforcement provisions, the decision creates a serious dysfunction in the statute and will cause the "mutually exclusive pockets of federal and state jurisdiction within a plan" against which this Court warned in *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987), and *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 99, 107-08 (1983).

Essentially ignoring these important considerations of national uniformity and ERISA's intended preeminence, respondent argues, without any support in the statute or legislative history, that Congress intended very restrictive health care plan and civil enforcement coverage. (Opposition at 8-9). Unless overturned, this erroneous interpretation of ERISA health care regulation—which reflects a sharp conflict among at least five Circuits (Petition at 16-19)—will lead to 50 differing and conflicting sets of regulation by the states not merely for varying health care plans, but also for individual participants within these plans—the very "patchwork scheme of regulation" that ERISA was intended to avoid. *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987).

Consequently, the *Turnbow* decision is not of limited effect, as respondent argues. (Opposition at 8-9). To the contrary, since over 84% of employer-sponsored health care plans are insured, and 93% of all employers, self-funded and insured alike, delegate claims administration (Petition at 26-27), the negative impact of *Turnbow* and its recent California counterpart, *Sayble v. Blue Cross of Southern California*, 256 Cal. Rptr. 820 (Cal. Ct. App. 1989), will continue to be extraordinary indeed.

Contrary to respondent's view, this Court's recent unfunded vacation pay decision in *Massachusetts v.*

Morash, 57 U.S.L.W. 4429 (April 18, 1989), does not support her position at all. (Opposition at 7-8). Instead, it strongly confirms petitioners' ERISA coverage and preemption arguments. First, this Court observed that the reasonable views of the Secretary of Labor are entitled to "deference," citing *Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 843 (1984), among other cases. *Id.* at 4431. As shown in the Petition at 11-14, the Secretary's regulations governing insured health care plans in 29 C.F.R. § 2510.3-1(j) (1987)—which the Nevada Supreme Court ignored—plainly establish that The Bottle Stop's plan was ERISA-regulated. Second, this Court concluded that because ordinary vacation benefits are types of regular compensation that are typically "fixed, due at known times, and do not depend on contingencies outside the employee's control," they present none of the employee welfare benefit plan risks that ERISA was intended to address. In contrast, the Court observed that ERISA section 3(1) regulates plans which provide certain *health care* benefits —including "medical, sickness [and] accident . . . benefits"—which generally "accumulate over a period of time and are payable only upon the occurrence of a contingency outside of the control of the employee." *Id.*[1]

Respondent essentially argues that The Bottle Stop's health care plan, which covered her and three common law employees, was not ERISA-regulated because it was insured and was administered primarily by third par-

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[1] The Court also quoted with approval from the Secretary of Labor's explanation why the proposed regulations excluded certain types of regular compensation, including vacation leave, in contrast to "*hospitalization*" benefits, from ERISA's definition of "employee welfare benefit plan":

> [P]aid vacations . . . are not treated as employee benefit plans because they are associated with regular wages or salary, rather than *benefits triggered by contingencies such as hospitalization.* (emphasis added). *Id.* at 4431.

ties.[2] (Opposition at 8). Respondent contends, at core, that ERISA was not intended to regulate the administration, fiduciary responsibility, and reporting and disclosure for *insured* health care plans. Her argument, however, is completely refuted by ERISA's broad definition of "employee welfare benefit plan" as including "*any*" health care plan funded "*through the purchase of insurance or otherwise*" (emphasis added) in section 3(1), by the Secretary of Labor's governing regulations, and by ERISA's regulatory provisions which place the duty of reporting and disclosure[3] on the person who serves as "administrator," and its fiduciary responsibility provisions on "named fiduciaries" and trustees, sections 101, 103-104, 402-412, §§ 1021, 1023-24, 1102-1112; *see also* sections 502, 503, §§ 1132, 1133. In addition, Congress phrased ERISA's preemption clause, and the administration and civil enforcement provisions, very broadly, and

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[2] The uncontroverted record, moreover, showed that the plan was established not by Turnbow as an individual, but by The Bottle Stop as an employer. The Bottle Stop submitted the application and not only selected the "American Series Plan" as one of several programs offered by B.E.S.T. and paid all insurance premiums for over eight years, but participated in the plan's administration by obtaining enrollment cards from all four individuals, having its insurance agent explain the coverage to the participants, and by paying an enrollment fee and monthly service charges. (Petition at 3-4).

[3] Contrary to respondent's view, these reporting and disclosure requirements—for insured plans established by small employers—are essentially *de minimis*. (Opposition at 8). The Department of Labor has exempted insured welfare plans covering fewer than 100 participants from various of ERISA's reporting and disclosure requirements, including the filing of the plan description, the summary plan description, the description of material modifications, the annual report, and a terminal report. 29 C.F.R. § 2520.104-20(a) (1987). A similar exemption applies to welfare plans with fewer than 100 participants when they are part of a group insurance arrangement (two or more unaffiliated employers) which uses a trust or other legal entity such as a trade association as the holder of the insurance contracts and the conduit for the payment of premiums to the insurer. 29 C.F.R. § 2520.104-21, .104-43 (1987).

did not limit them in any way to *employer* conduct. Sections 514(a), 501-504, 510-511, §§ 1144(a), 1131-1134, 1140-1141.

Consequently, ERISA coverage of insured health care plans is fully consistent with the regulatory concerns addressed by this Court in both *Morash* and *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987): the promotion of efficient administration through the preemption provision, and the protection of plan assets through the fiduciary liability provisions.[4] The efficient administrative scheme which Congress intended to promote in enacting ERISA's preemption provision, and the Act's fiduciary concerns, would be impermissibly burdened by conflicting state regulation of *health care* plans regardless of whether the covered plan is self-funded or insured, and an employer or an insurance company serves as administrator or claims review fiduciary under ERISA section 503, 29 U.S.C. § 1133.

Most significantly, respondent ignores the destructive impact that *Turnbow* and *Sayble*—both of which are the opportunistic progeny of the conflict and confusion created by *Taggart Corp. v. Life & Health Benefits Admin. Inc.*, 617 F.2d 1208 (5th Cir. 1980), *cert. denied*, 450 U.S. 1030 (1981)—will have on the continued provision of health insurance to families across the country.

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[4] The reason that this Court determined in *Fort Halifax* that the Maine severance pay statute did not implicate ERISA's preemption and fiduciary concerns was that the benefit mandated by the Maine statute required no administration. Under *Fort Halifax*, whether the concerns of ERISA's preemption and fiduciary provisions are implicated turns on the existence of an administrative scheme—which in case of health care plans would include procedures for enrolling new participants, advising them of their rights and, most importantly, for the process and review of claims—not on the duration of the plan, how it is funded, or who administers it. *Id.* at 9.

These decisions, by exposing insured health care plans to conflicting regulation and suits under state law, will lead to increased transaction costs and hence to a reduction in benefits, a self-funding of plans, or to their abandonment altogether. *See amicus* brief filed by the Solicitor General, on behalf of the United States, at 7-8, in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 1 (1987). As this Court stated in *Fort Halifax*, "[f]aced with the difficulty or impossibility of structuring administrative practices according to a set of uniform guidelines, an employer may decide to reduce benefits or simply not to pay them at all." 482 U.S. at 13.

In summary, the *Turnbow* decision, though posing a formidable obstacle to congressional aims, stands at the wrong edge of the tide. Notwithstanding Congress' express intent that ERISA encourage the growth and development of employee benefit plans, ERISA section 2(a), 29 U.S.C. § 1001(a), the lack of employer-sponsored health insurance is an increasingly severe national problem more than a dozen years after ERISA's enactment. *See* Employee Benefit Research Institute study, *Uninsured in the United States: The Nonelderly Population Without Health Insurance, 1986* (1988). The study shows that in 1986, *37 million* persons, representing approximately 18 percent of the civilian population under age 65 (nearly 1 out of 5), reported *no* health insurance coverage from any source; that this proportion was substantially *greater* than the percentage reporting no health insurance in the early 1980's; and that nearly 88% of the uninsured population were either themselves *workers* or lived in the families of workers, and the family income in about one-half of these cases was *less* than $15,000 per year. (EBRI study at 2-3). The *Turnbow* decision—which is indefensible on any ground—will not only deliberately undercut ERISA's preeminence over employer-sponsored health care plans, but will also exacerbate this shortfall of health insurance nationwide.

For the foregoing reasons, as well as the grounds advanced in the Petition and by the *amici curiae*, a writ of certiorari should issue to review the judgment and opinion of the Nevada Supreme Court.

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